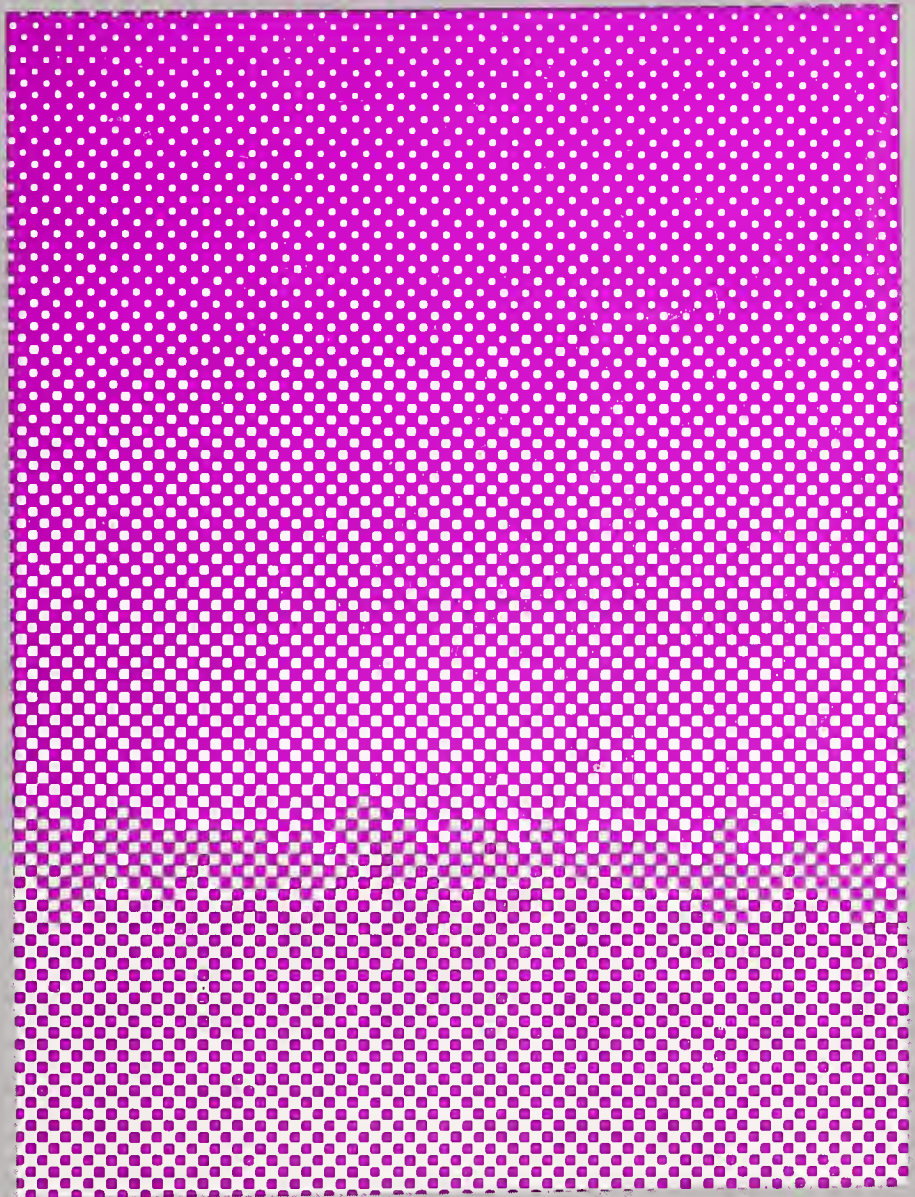


MEDICARE HOSPITAL MORTALITY INFORMATION



Volume I

Alabama - California



U.S. Department of Health and Human Services
Health Care Financing Administration

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MEDICARE HOSPITAL MORTALITY INFORMATION

1986

VOLUME I

ALABAMA - CALIFORNIA

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U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES**

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The Health Care Financing Administration (HCFA) was established on March 9, 1977, to combine health financing and quality assurance programs into a single agency. HCFA is responsible for the Medicare program, Federal participation in the Medicaid program, the Peer Review Organization program and a variety of other health care quality assurance programs.

The mission of the Health Care Financing Administration is to ensure the effective administration of our programs in order to promote the timely delivery of appropriate, quality health care to over 56 million of the nation's aged, disabled and poor. The agency must also ensure that beneficiaries are aware of the services for which they are eligible, that those services are accessible and of high quality and that agency policies and actions promote efficiency and quality within the total health care delivery system.

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INTRODUCTION

The nation's Medicare program, which is administered through the Health Care Financing Administration (HCFA) of the Department of Health and Human Services, now has 31 million beneficiaries. One of HCFA's primary responsibilities is to ensure that Medicare beneficiaries receive quality health care. We believe that the publication of the information contained in this document will contribute to that end.

This particular information release, presents information to answer the question: "What is the actual death rate for each hospital compared to what would have been expected for that particular hospital given what we know of the characteristics of patients admitted?" The statistics are presented in the hope that they will serve the public and the hospitals in their common interest of improving quality of care.

The development of mortality statistics is a complicated and controversial task since the mortality rate at a given hospital reflects, among other factors, age, sex, diagnosis, and severity of illness of patients admitted to that hospital, as well as the purpose and quality of the care they received. Characteristics affecting health and the probability of death vary among the patient populations served by individual hospitals. Consequently, the mortality rates in different patient populations will vary.

The usefulness of this information depends upon the accuracy with which mortality rates can be predicted and the stability of these rates over time for each hospital. It is important to understand that the predicted values in the tables contained in this document are not a direct measure of the quality of care rendered in hospitals. There is one primary reason for this. We do not now have any direct measurement tool with which we can adjust fully for differences among hospitals in how severely ill their patients are. For instance, two hospitals might have very different death rates for patients admitted for stroke, even after we have adjusted for age and sex. This might happen because one hospital's stroke patients consist of a significant number admitted in a coma and are thus likely to die, whereas another hospital's patient population represents a broader spectrum of patients with cerebrovascular problems, or because these hospitals in fact provide different levels of quality. In addition, other factors affecting the probability of death in a particular case, e.g., family status/support, and overall health status are not included in the predictive model because information on them is not readily available.

When properly understood and used, this information can be useful; it can also be very misleading if it is interpreted incorrectly. The information simply describes one aspect of individual hospital performance--post admission mortality for Medicare beneficiaries. The information is not necessarily representative of a hospital's total performance in all aspects of patient care, and is best used to view experience in individual hospitals rather than making comparisons among hospitals. Individual hospitals may have very good reasons for their rates being higher than the ranges predicted by HCFA's model. Accordingly, it was important for hospitals to have an opportunity to review their specific information and to provide comments to HCFA and the public. We asked each hospital to prepare its comments on the information being released to the public, and we are including those comments in this publication.

The information is an important contribution to the health care community and should be reviewed by a wide range of individuals and organizations including hospital administrators, Peer Review Organizations, physicians and researchers. Among these audiences, perhaps the hospital administrator will find the information most useful--as a screening tool and in consulting with medical staff to evaluate a hospital's strengths and weaknesses. In this way, the information should lead to analysis and subsequent actions which will capitalize on areas of strong performance and strengthen areas where improvement is needed. For example, we expect that hospitals and their medical staffs, using established and newly emerging quality assessment techniques, will try to determine what useful information can be derived about how they function.

Consumers should read the explanations of the uses and limitations of the information, as well as any comments a hospital may have provided, and should carefully consider the different roles that different hospitals play in their community. For example, one hospital might have different death rates than another because it serves more severely ill patients, because it specializes in difficult illnesses, or because it is a trauma or emergency center.

The development and presentation of this information is an important part of HCFA's responsibilities in the health care community, and follows nearly a full year of effort. In making the information as accurate and useful as possible, we discussed the theoretical framework and statistical approach with a number of national experts in appropriate fields. As a result, we believe the models used in this work are reasonable and appropriate for the intent of the publication. In addition, the format for presentation, the process for sharing the information with individual hospitals, and the statistical methodology have been discussed at a series of meetings with leaders of organizations representing Medicare beneficiaries, doctors and hospitals, and a great many suggestions from these groups have been incorporated into the final approach.

We are continuing to do everything we can to make these types of information more useful to both the public and the health care professions. We are refining ways to use the information as a screening tool for "quality of care" purposes, and we are developing tools to adjust for the differences in disease severity highlighted earlier. In addition, because we recognize that mortality rates alone do not adequately measure how effectively a hospital cares for its patients, we will be developing other measures of outcome, such as the kind of medical treatment needed after discharge, to assess the performance of hospitals more fully.

We have begun what will be a continuing effort involving all interested parties to improve the accuracy of outcome predictions by refining the model and the methodology. This will contribute to assessment of and improvement in the effectiveness of medical services.

A handwritten signature in dark ink that reads "William L. Roper M.D.". The signature is written in a cursive, flowing style.

William L. Roper, M.D.
Administrator

DESCRIPTION OF INFORMATION

Before reading the tables containing the hospital specific information and the comments provided by individual hospitals, it would be useful to understand the format and presentation of the information in this document.

The information is presented in alphabetical order by state and by hospital within the state. For each hospital, information is presented for overall Medicare patient mortality and each of 16 diagnostic categories. The information consists of the number of Medicare patients, the actual mortality rate, and a range of predicted mortality given the mix of patients. It would be helpful to describe how the numbers were derived and what they represent.

- o Number of Patients. This figure represents the number of individual Medicare beneficiaries whose last discharge from a short term, acute care hospital in 1986 was from the hospital listed. The total number for each hospital is presented under the category "overall." Similarly, for each diagnostic category, the number of patients consists of the number of Medicare beneficiaries whose last discharge in 1986 was from the hospital cited and whose primary diagnosis fell within the specific diagnostic category. (Generally the number of patients in the sixteen diagnostic categories will total between 70 percent and 80 percent of the figure for "overall." The remaining 20 percent to 30 percent represent diagnoses that do not fall within the 16 diagnostic categories specifically studied.)

Since only a patient's last hospital discharge is "counted" in the total number, HCFA's computation and that maintained by individual hospitals will generally differ. For example, if John Doe was a patient at Hospital A three times during 1986, the methodology used in HCFA's analysis counts only the last admission in the hospital's total. Normally a hospital will maintain statistics based on numbers of admissions and so would count Mr. Doe as three cases. In addition, in this example, if Mr. Doe were admitted later in the year to Hospital B (another acute care hospital) and then discharged in 1986, and this latter stay represented his last discharge for 1986, his case would be counted in Hospital B's total and he would not appear at all in Hospital A's count.

The key factor to remember is that we are examining last hospital discharges in 1986. In some cases, this will necessitate the inclusion of patients admitted to the hospital in December 1985 or those who died in January 1987.

- o Actual Mortality Rate. This figure presents the percentage of each hospital's Medicare patients who died within 30 days of the admission that resulted in the last-occurring discharge of the patient in 1986. (The percentage is rounded to the nearest whole percentage point.)

Where, for example, Hospital A had a universe of 1000 patients whose last acute care hospital discharge in 1986 was from Hospital A, and 100 of these patients died within 30 days of that last admission, whether as hospital inpatients or after discharge, the actual mortality rate would be 10 percent. This rate includes cases in which a beneficiary was admitted to the hospital in 1985, was discharged in 1986 and died within 30 days of admission. It also includes those instances in which a beneficiary was discharged in 1986 and died within 30 days of admission even though the 30 day period extends into 1987. Cases in which the beneficiary was not discharged in 1986

are not part of the rate, even though an individual may have died in 1986 or have died within 30 days of last hospital admission. For example, a person admitted to a hospital on December 20, 1985, who was discharged on December 30, 1985 and who died on January 2, 1986 is not part of the calculation since the person was not discharged in 1986. Similarly, a person admitted to a hospital on December 28, 1986 who was discharged on January 5, 1987 and died on January 8, 1987 would not be a part of the calculation even though he or she died within 30 days of a 1986 admission.

- o Range of Predicted Mortality. This column gives an estimate of mortality rates for patients equal in number and similar in characteristics to those treated by the hospital. The range is derived in part by determining, based on national experience, the relative risk of dying associated with various patient characteristics: previous hospital admission(s), transfer status, age, sex, and presence of up to eight comorbid conditions (cancer, cardiovascular disease, cerebral degeneration/psychosis, pulmonary disease, renal disease, liver disease, diabetes, hypertensive disease) and by applying weights of the risk factors to the actual number of patients at the hospital to enable compilation of an expected mortality rate. This rate is converted, through statistical techniques, to a range of predicted mortality rates. It is important to note that the fewer the number of cases included in a given diagnostic category, the greater the uncertainty of the expected mortality range, and therefore, the wider the range. A larger number of cases yields greater precision, and therefore, a more narrow range of predicted mortality rates.

HOSPITAL COMMENTS

On September 21, 1987, HCFA mailed to each hospital its own mortality information and asked for comments by October 28, 1987. These comments are arranged alphabetically by state and are included in this publication immediately after the tables presenting information for all the hospitals in a given state. The entry for each hospital on the state charts indicates where to find the hospital's comments and presents a notation (asterisk) advising of the absence of hospital comments. The page number where the comments of the hospital are presented is given next to the name and address of the hospital.

The comments are generally reproduced as submitted by the hospital. However, some hospitals returned to HCFA, an annotated copy of the information sent on September 21. These annotated materials have not been reproduced in this publication, even in those instances where they were the only form of comments submitted by a hospital. The reason for not printing these materials is one of privacy. Information which would identify or possibly identify patients must be deleted, and consequently any remaining information would be very confusing and of extremely limited use, if not totally useless. Therefore, we have included a statement to identify instances when these types of materials have not been included. As mentioned earlier, it is extremely important that the information presented in the tables be reviewed in concert with the hospital's comments.

In any project of this size, there will be instances where hospitals did not receive the information for comment or did not receive it timely. In fact, many hospitals were sent second copies of their specific information in an expeditious manner to allow every opportunity for review/study and comment. Although we have received over 2,600 comments out of a possible 5,971, it is possible that some of the non-responding facilities never got the information or did not have adequate time to comment. However, we expect these instances were few in number.

INFORMATION SOURCES AND NOTES

It is important to note that this publication is based primarily on analysis of Medicare hospital billing information for calendar year 1986. While information about beneficiaries, was obtained from the Social Security Administration (SSA), the principal source for the analysis was the HCFA maintained MEDPAR file which contains information about each Medicare hospitalization. Hospitals submit such information to HCFA's fiscal intermediaries (which pay hospitals for the care provided to Medicare beneficiaries). The file is updated quarterly. It is estimated that billing information on approximately 95% of all Medicare discharges is included in the MEDPAR file within 6 months of the close of the calendar year. Accordingly, our analysis was based on information received through June 30, 1987.

In any large scale data base such as one dealing with Medicare hospitalizations, there will be gaps or inaccuracies. The fact that the files contain information on about 10 million hospital admissions to nearly 6,000 hospitals provides some assurance that for purposes of the statistical analysis conducted here, the information which might be missing or inaccurate is such a small portion of the total that it would have almost no impact on the results.

Nonetheless, while we feel that the information used in this analysis is quite thorough and complete, there are a few points which should be kept in mind as the hospital specific information is being reviewed.

- o The information used is billing data and is only as good as the information submitted by hospitals as a part of the payment process. Although there is always a possibility that coding errors are included, the assumption is that hospitals do not make errors on billing forms which ultimately affect payment to them. Likewise, it is assumed that given the link to payment, hospitals have an incentive to submit bills promptly.
- o The hospitals included in this analysis are short-term, acute care facilities which were identified by their unique provider number. All facilities which have a zero in the third column of their provider number are by definition participating in Medicare as short-term, acute care facilities. All other facilities--those with something other than a zero in the third column of the provider number--were excluded from the analysis. In some cases, hospital names suggest an orientation different from acute care. This does not mean the facility is inappropriately included in the publication.
- o There is some information in the file which does not reflect the results of review by Peer Review Organizations (PROs), the entities charged with reviewing hospital services provided to Medicare beneficiaries. For example, one of the functions a PRO performs is to ensure that the diagnosis assigned to a particular case is accurate. The nature of the review and payment system is such that it is possible for PRO changes in diagnosis assignment not to be submitted to HCFA and associated in the MEDPAR file on as timely a basis as other billing information. Obviously, any major changes in diagnosis assignment which are not reflected in the data base would have a bearing on calculation of mortality rates in individual diagnostic categories and may also have a bearing on the extent to which presence or absence of comorbidities has been reflected accurately.

Some hospitals pointed out instances where the hospital's information did not agree with HCFA's, e.g., different date of death, cases of subsequent admission to another facility, or changes in diagnosis codes. The data base used in this analysis has not been revised to reflect these potential discrepancies. Rather we are examining all hospital comments to ensure that changes to our data systems and processes can be made when warranted so that future releases will be even more accurate. Readers are urged to review any hospital comments with a specific view toward these types of issues.

- o The predictive model used in this effort does not explain all variability in outcome. Most notably, a measure of severity of illness has not been included in the model, and therefore, the predictive power of the model is less precise than it would be if such a measure had been available. Nonetheless, the information included in this document does legitimately contribute to the body of information about hospital performance.



Alabama

Medicare Hospital Mortality Information

HOSPITALS		High Risk Diagnostic Categories																							
		Overall			Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
ABERNETHY MEMORIAL HOSP- FLOMATION AL 36441	AL-13 *	111	14	6-20	2	100	7-95	2	50	1-89	2	50	0-90	5	0	3-70	3	100	10-91	2	0	0-92	17	18	5-43
AMI BROOKWOOD MEDICAL CENT BIRMINGHAM AL 35209	AL-14	3413	9	6-13	244	27	19-35	90	22	19-39	43	21	8-33	89	24	13-31	91	46	30-52	55	13	8-32	189	17	12-26
AMI WEST ALABAMA GENERAL H NDRTHPORT AL 35476	AL-15	1172	11	8-15	74	28	17-40	47	34	16-42	17	18	3-40	34	26	12-40	26	27	22-58	30	13	8-40	108	18	12-29
ARAB HDSP ARAB AL 35016	AL-16	340	12	8-17	6	17	2-64	21	19	13-50	16	13	3-41	21	33	9-44	15	40	18-64	25	16	7-41	45	24	8-31
ATHENS LIMESTONE HOSP- ATHENS AL 35611	AL-17 *	833	10	9-16	42	26	22-52	36	42	17-47	20	10	6-41	46	24	11-36	31	32	23-57	23	26	8-43	56	18	11-34
AUTAUGA MEDICAL CENTER PRATTVILLE AL 36067	AL-18	472	13	7-16	18	50	15-58	17	29	12-54	15	40	3-42	26	38	10-42	12	33	15-66	9	33	4-56	65	18	10-30
BAPTIST MEDICAL CTR MONTGOMERY AL 36198	AL-19	2344	10	8-14	185	21	18-35	104	26	19-37	46	20	9-34	71	15	14-34	53	40	25-52	44	9	9-36	175	18	11-25
BAPTIST MEDICAL CTR CHEROK CENTRE AL 35960	AL-20 *	359	21	9-19	11	73	8-59	13	54	12-59	13	54	9-56	17	35	9-48	21	43	17-57	11	27	7-57	50	34	11-35
BAPTIST MEDICAL CTR DEKALB FORT PAYNE AL 35967	AL-21 *	975	15	11-18	55	22	15-40	36	33	17-47	15	27	9-53	33	36	12-42	37	35	21-52	48	25	13-41	124	23	15-32
BAPTIST MEDICAL CTR MONTCL BIRMINGHAM AL 35213	AL-22	3984	10	8-14	255	18	18-34	118	19	20-38	39	15	5-30	180	27	16-29	131	42	30-49	83	20	10-32	297	17	14-26
BAPTIST MEDICAL CTR PRINCE BIRMINGHAM AL 35211	AL-23	4098	11	9-15	287	24	18-33	136	27	21-38	79	22	9-29	144	23	15-29	104	35	28-49	83	39	14-36	418	20	15-26
BAPTIST MEMORIAL HOSP- GADSDEN AL 35999	AL-24	2195	11	8-15	127	24	16-35	98	27	18-37	37	16	7-34	93	31	15-33	79	28	27-50	46	28	11-38	225	20	13-26
BESSEMER CARRAWAY MEDICAL BESSEMER AL 35023	AL-25	1555	13	9-16	72	36	15-38	58	14	19-43	19	11	4-39	83	27	16-35	50	36	26-54	33	21	6-35	155	22	13-28
BIBB MEDICAL CENTER HOSP CENTREVILLE AL 35042	AL-26 *	216	22	12-24	2	50	2-90	12	33	11-60	7	14	2-60	13	38	8-54	14	64	19-67	10	10	5-55	33	33	10-39
BLOUNT MEMORIAL HDSP ONEONTA AL 35121	AL-27	713	9	9-17	17	65	17-61	32	34	18-50	15	13	4-44	12	17	7-53	50	12	26-53	7	0	4-63	147	10	10-24
BDAZ ALBERTVILLE MEDICAL C BOAZ AL 35957	AL-28	1026	18	11-18	34	32	14-45	62	39	18-41	28	14	6-36	46	33	12-36	50	48	28-55	54	22	10-35	152	32	15-30
BRYAN W WHITFIELD MEM HOSP DEMOPOLIS AL 36732	AL-29	619	13	9-17	16	69	11-54	21	29	16-55	14	14	3-43	44	18	11-35	10	60	18-73	35	14	9-39	97	16	12-29
BULLOCK CO HOSP UNIDN SPRINGS AL 36089	AL-30 *	120	10	6-20	.	.	.	3	33	3-83	2	0	0-93	12	25	6-52	4	50	8-83	7	0	3-62	16	13	4-42
BURDICK-WEST MEMORIAL HDSP HALEYVILLE AL 35565	AL-31 *	469	13	8-16	6	83	7-72	24	46	15-52	8	13	3-57	16	50	9-50	12	67	17-68	19	0	4-40	62	15	12-33
CARRAWAY METHODIST MEDICAL BIRMINGHAM AL 35234	AL-32	3523	11	9-15	192	18	16-33	129	29	19-36	59	15	9-32	132	17	17-32	172	33	29-45	84	27	13-35	245	18	14-27
CENTRAL ALABAMA COMMUNITY CLANTON AL 35045	AL-33	361	17	9-18	9	67	14-71	20	60	15-54	6	17	2-63	22	18	9-44	17	47	20-64	15	13	4-45	36	28	11-40
CHAMBERS CO HOSP LAFAYETTE AL 36862	AL-34	153	14	9-21	4	100	5-79	12	25	11-59	5	0	1-68	4	25	2-75	6	83	14-81	8	25	4-60	19	21	8-46
CITIZENS HOSP ASSOCIATION TALLADEGA AL 35160	AL-35	823	13	6-14	42	43	14-42	34	41	15-46	22	32	7-41	42	17	10-34	28	36	19-54	20	0	2-37	92	16	8-24
CLARKE HOSP JACKSON AL 36545	AL-36 *	285	11	10-20	6	83	14-81	9	33	10-66	9	0	3-55	22	5	8-42	11	18	18-71	18	17	7-46	53	15	11-34
CLAY CO HDSP ASHLAND AL 36251	AL-37 *	444	12	8-16	15	53	14-60	13	46	9-55	10	40	7-59	10	20	6-57	11	55	16-69	17	12	3-41	68	15	10-30
CLEBURNE COMMUNITY MEDICAL HEFLIN AL 36264	AL-38 *	158	14	10-23	1	0	0-99	8	38	9-67	2	0	1-89	11	27	10-61	4	50	10-85	15	20	8-51	30	20	12-44

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

AL-2

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Dphthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
ABERNETHY MEMORIAL HOSP- FLOMATON AL 36441	9	22	4-60				1	0	0-99				11	9	0-45	5	0	0-71				13	0	0-39	1	0	0-100
AMI BROOKWOOD MEDICAL CENT BIRMINGHAM AL 35209	39	5	5-39	15	33	14-61	57	18	3-20	116	0	0-9	292	5	2-8	191	7	2-11	48	2	0-46	430	3	3-7	268	1	0-4
AMI WEST ALABAMA GENERAL H NDRTHPORT AL 35476	16	19	8-53	10	40	13-68	39	21	4-25	3	0	0-100	138	4	2-10	48	2	1-17	5	0	0-100	76	4	1-12	111	3	0-7
ARAB HOSP ARAB AL 35016				1	0	0-97	1	0	0-99				38	3	0-18	28	0	1-24	4	0	0-100	39	5	1-17	7	0	0-89
ATHENS-LIMESTONE HOSP- ATHENS AL 35611	13	8	7-56	10	20	14-69	29	3	2-27	18	0	0-96	102	5	2-12	78	3	1-14	19	0	0-96	49	2	1-15	41	0	0-18
AUTAUGA MEDICAL CENTER PRATTVILLE AL 36067	6	17	1-66	3	33	3-83	12	8	1-42				51	6	1-16	18	6	1-32				70	0	1-12	23	4	0-39
BAPTIST MEDICAL CTR MONTGOMERY AL 36198	19	11	6-48	37	38	22-55	79	10	4-18	27	0	0-40	246	3	3-9	137	4	1-12	36	6	0-30	141	3	2-10	173	1	0-5
BAPTIST MEDICAL CTR CHERDX CENTRE AL 35960	14	43	7-55	1	100	1-97							38	5	1-18	9	0	1-50	2	0	0-100	33	9	1-20	9	11	0-65
BAPTIST MEDICAL CTR DEKALB FORT PAYNE AL 35967	27	19	13-53	18	56	21-66	14	0	3-41				140	7	2-11	43	5	1-18	12	0	0-96	93	4	1-11	15	0	0-53
BAPTIST MEDICAL CTR MONTCL BIRMINGHAM AL 35213	21	24	11-53	21	43	16-57	89	11	4-17	7	0	0-100	396	4	3-9	106	8	2-13	22	0	0-46	635	3	3-7	269	1	1-5
BAPTIST MEDICAL CTR PRINCE BIRMINGHAM AL 35211	41	20	9-42	74	34	23-49	79	16	4-18	7	0	0-100	456	5	3-8	149	5	2-11	23	0	0-85	479	3	3-7	212	0	0-5
BAPTIST MEMORIAL HOSP- GADSDEN AL 35999	18	33	8-51	23	43	19-59	60	5	3-20	5	0	0-100	208	6	3-10	100	11	2-14	16	0	0-98	226	3	2-8	157	0	0-6
BESSEMER CARRAWAY MEDICAL BESSEMER AL 35023	29	24	11-49	22	59	22-63	45	9	4-23	1	0	0-100	184	5	2-10	95	6	2-14	17	0	0-97	146	3	3-11	73	1	0-10
BIBB MEDICAL CENTER HOSP CENTREVILLE AL 35042	9	33	5-61	12	67	19-71	2	0	2-90				21	0	1-28	10	10	1-48	1	0	0-100	17	0	1-32	3	0	0-99
BLOUNT MEMORIAL HOSP DNEINTA AL 35121	4	0	1-76	9	33	18-77	2	0	0-95	1	0	0-100	74	1	1-13	24	0	2-28				101	1	2-11	11	0	0-53
BOAZ ALBERTVILLE MEDICAL C BOAZ AL 35957	30	47	14-52	17	29	18-63	18	11	1-33				153	5	2-11	45	4	1-19	7	0	0-100	116	2	2-10	18	6	0-31
BRYAN W WHITFIELD MEM HDSP OEMOPOLIS AL 36732	20	5	7-49	11	64	16-69	11	27	1-44	1	0	0-100	92	4	2-13	19	11	1-31	2	0	0-100	39	0	1-18	34	0	0-26
BULLOCK CO HDSP UNION SPRINGS AL 36089	4	25	1-76	2	0	2-91							6	0	0-86	4	0	1-73				20	0	1-28			
BURDICK-WEST MEMORIAL HOSP HALEYVILLE AL 35565	7	29	4-65	1	100	3-99	1	0	0-100				57	5	2-15	12	0	1-42	3	0	0-100	67	3	1-12	15	0	0-47
CARRAWAY METHOOIST MEDICAL BIRMINGHAM AL 35234	29	17	9-46	41	41	23-56	113	14	5-17	34	0	0-40	358	4	3-9	177	10	3-12	28	0	0-64	500	5	3-8	210	0	0-5
CENTRAL ALABAMA COMMUNITY CLANTON AL 35045				4	0	6-81	2	0	0-99				47	9	1-15	12	8	1-42	1	0	0-100	36	11	1-18	10	10	0-77
CHAMBERS CO HOSP LAFAYETTE AL 36862				4	0	5-80	1	0	0-100				16	6	0-36	6	0	1-62				18	0	0-31	3	0	0-99
CITIZENS HOSP ASSOCIATION TALLADEGA AL 35160	11	9	3-53	1	0	0-97	15	7	1-36	8	0	0-100	112	5	1-9	49	12	1-17	9	0	0-100	60	7	1-13	25	0	0-43
CLARKE HDSP JACKSON AL 36545	8	13	4-63	1	0	3-99							22	5	1-27	3	0	0-99	1	0	0-100	33	6	1-20	14	0	0-37
CLAY CO HOSP ASHLAND AL 36251	7	0	4-65	8	38	12-72	3	0	2-81				56	9	1-15	12	8	1-42	1	0	0-100	39	5	1-18	19	0	0-33
CLEBURNE COMMUNITY MEDICAL HEFLIN AL 36264	2	100	1-90	2	50	5-93	1	0	0-98				8	13	1-53							24	0	1-25			

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		High Risk Diagnostic Categories																							
		Overall			Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
Name/Location	Comment/Reference																								
COLUMBIA REGIONAL MEDICAL AVALUSIA AL 36420	AL-39 *	166	16	7-19	2	100	5-93	3	0	4-84				15	0	5-45	12	75	20-71	7	14	1-59	23	26	7-39
COMMUNITY HOSP INC TALLASSEE AL 36078	AL-40	693	13	9-16	21	52	18-59	23	43	15-52	12	33	6-52	36	31	15-44	18	61	19-62	12	17	6-52	109	17	12-28
COMMUNITY HOSP OF COURTLAN COURTLANO AL 35618	AL-41 *	82	4	6-22	1	100	1-97	3	0	3-83				3	0	2-81	5	40	13-83	6	0	2-65	7	0	3-61
COOPER GREEN HOSP BIRMINGHAM AL 35223	AL-42 *	661	17	9-16	44	36	14-41	32	28	13-44	15	20	5-46	34	24	8-35	19	47	21-63	40	23	5-32	73	27	8-26
CRENSHAW CO HOSP LUVERNE AL 36049	AL-43 *	353	14	7-15	9	56	12-69	11	55	7-56	5	40	3-70	14	43	9-53	5	60	9-79	16	19	7-48	56	14	9-30
CRESTWOOD HOSP HUNTSVILLE AL 35801	AL-44 *	717	9	9-16	59	19	14-39	20	20	13-52	7	29	4-63	18	28	8-46	23	52	21-60	32	16	6-36	80	16	12-32
CULLMAN MEDICAL CENTER CULLMAN AL 35056	AL-45 *	1186	11	8-15	61	30	15-39	39	26	16-45	29	24	7-37	53	26	14-37	42	36	24-54	28	21	8-41	121	21	12-29
D C H REGIONAL MEDICAL CEN TUSCALOOSA AL 35403	AL-46 *	4142	8	8-14	213	23	19-36	113	27	20-38	88	22	9-28	151	16	15-30	120	21	27-46	106	15	13-34	410	14	15-26
O C H REHABILITATION PAVIL TUSCALOOSA AL 35401	AL-47 *	185	2	4-14																					
D E JACKSON MEMORIAL HOSP LESTER AL 35647	AL-48 *	57	12	7-26	4	75	7-81	3	67	7-88	1	0	1-97	2	0	0-89	1	0	1-98	3	33	1-81	6	0	5-69
O W MC MILLAN MEMORIAL HOSP BREWTON AL 36426	AL-49 *	679	11	7-14	36	42	20-52	22	45	13-50	16	19	6-47	16	25	6-45	6	17	10-76	10	20	2-51	69	16	9-29
DALE CO HOSP OZARK AL 36360	AL-50 *	670	12	9-17	26	46	12-46	19	21	13-53	16	6	4-43	27	26	11-43	20	55	19-60	25	12	9-43	114	18	12-28
DECATUR GENERAL HOSP- DECATUR AL 35602	AL-51 *	1345	10	8-15	79	22	16-38	64	25	18-41	20	10	5-40	53	26	12-35	40	38	27-57	33	12	7-36	118	22	12-28
DOCTORS HOSP OF MOBILE INC MOBILE AL 36604	AL-52	812	8	6-13	80	14	12-33	19	21	11-49	12	17	5-50	30	23	11-41	13	23	15-63	12	33	5-51	69	16	10-30
EAST ALABAMA MEDICAL CENTE OPELIKA AL 36802	AL-53	2079	9	7-14	131	29	18-37	73	19	16-37	35	14	9-38	67	16	12-32	49	37	23-51	37	19	9-38	149	16	12-27
EDGE MEM HOSP TROY AL 36081	AL-54 *	868	10	8-15	31	42	15-47	41	37	16-44	25	12	5-37	63	21	13-35	23	39	20-58	38	18	8-36	89	10	10-27
ELBA GENERAL HOSP- ELBA AL 36323	AL-55 *	164	16	10-22	2	100	6-94	7	29	8-70	2	0	1-89	7	43	7-67	3	67	8-89	11	18	6-55	44	11	8-32
ELIZA COFFEE MEMORIAL HOSP FLORENCE AL 35631	AL-56 *	2324	10	8-14	123	28	17-36	65	17	16-38	36	11	9-37	120	21	15-31	92	48	27-48	53	19	9-34	186	18	12-26
ELMORE CO HOSP WETUMPKA AL 36092	AL-57	378	12	9-18	13	38	16-66	19	37	13-53	5	0	1-68	26	19	11-44	13	46	17-66	8	13	6-63	55	15	10-33
ENTERPRISE HOSP ENTERPRISE AL 36331	AL-58 *	275	14	8-17	6	0	2-64	4	50	4-77	4	0	1-74	8	13	4-59	10	70	25-80	9	0	3-55	42	40	11-37
EVERGREEN HOSP EVERGREEN AL 36401	AL-59 *	332	12	9-19	1	0	0-98	5	60	7-77	4	50	1-74	26	19	11-43	10	40	15-70	9	22	5-58	56	18	10-32
EYE FOUNDATION HOSP- BIRMINGHAM AL 35233	AL-60 *	339	0	0-12	6	0	1-63																		
FAYETTE CO HOSP FAYETTE AL 35555	AL-61	423	10	9-18	13	54	12-60	19	32	13-53	9	22	3-54	22	23	10-45	19	21	20-62				85	16	12-31
FLORALA MEMORIAL HOSP FLORALA AL 36442	AL-62 *	95	3	4-18				1	0	1-97	3	33	1-81				3	0	8-89	10	0	1-50	9	0	3-54
FLOWERS HOSP INC OOTHAN AL 36301	AL-63 *	2265	8	7-14	122	27	18-38	53	25	16-40	37	14	9-37	96	23	15-33	67	34	23-47	63	10	11-35	149	11	13-28
GEORGE H LANIER MEM HOSP LANGDALE AL 36864	AL-64	1159	10	8-15	56	29	17-42	45	24	16-43	15	40	6-48	55	20	14-37	21	62	19-59	36	14	9-38	87	20	10-28

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

AL-4

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Dphthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Drthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
COLUMBIA REGIONAL MEDICAL ANDALUSIA AL 36420	1	0	0-98	1	0	0-97	2	0	0-92	.	.	.	7	0	0-67	1	0	0-100	.	.	.	52	4	1-14	9	0	0-91
COMMUNITY HOSP INC TALLASSEE AL 36078	7	14	2-63	9	44	16-74	.	.	.	2	0	0-100	83	5	1-12	42	2	1-19	.	.	.	95	2	2-12	20	0	0-29
COMMUNITY HOSP OF COURTLAN COURTLAND AL 35618	2	0	6-94	.	.	.	.	.	.	.	.	.	6	0	0-81	2	0	0-92	1	0	0-100	13	0	0-40	5	0	0-91
COOPER GREEN HOSP BIRMINGHAM AL 35223	15	13	5-50	21	76	15-56	21	10	1-29	8	13	0-99	50	4	1-15	25	12	1-27	5	0	0-100	42	5	1-17	15	0	0-49
CRENSHAW CO HOSP LUVERNE AL 36049	2	0	3-91	1	0	2-98	7	14	0-62	.	.	.	44	9	1-17	15	7	0-50	.	.	.	34	9	1-19	7	0	0-96
CRESTWOOD HOSP HUNTSVILLE AL 35801	8	13	5-64	9	11	9-65	21	0	3-34	9	0	0-96	63	0	2-15	50	0	1-18	7	0	0-100	54	0	1-15	46	0	0-16
CULLMAN MEDICAL CENTER CULLMAN AL 35056	25	8	11-51	5	40	5-74	33	9	3-25	2	0	0-100	167	1	2-9	51	8	1-18	15	0	0-96	118	0	1-10	46	0	0-17
D C H REGIDNAL MEDICAL CEN TUSCALOOSA AL 35403	46	13	10-42	46	43	26-57	71	15	4-19	17	6	0-84	441	2	3-8	227	5	2-11	28	0	0-74	452	3	3-7	224	1	0-5
D C H REHABILITATION PAVIL TUSCALOOSA AL 35401	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
D E JACKSON MEMORIAL HDSP LESTER AL 35647	.	.	.	.	.	.	1	0	0-100	.	.	.	8	0	0-59	4	0	1-73	2	0	0-100	6	17	0-65	.	.	.
D W MCMILLAN MEMDRIAL HOSP BREWTON AL 36426	20	10	4-45	8	38	10-69	7	0	1-58	.	.	.	119	4	2-10	18	6	1-32	5	0	0-100	78	6	1-12	25	4	0-36
DALE CO HOSP OZARK AL 36360	6	67	10-77	8	50	9-68	15	0	2-37	.	.	.	83	0	2-13	40	8	2-21	6	0	0-100	63	2	1-14	29	3	0-22
DECATUR GENERAL HDSP- DECATUR AL 35602	22	27	5-45	13	15	17-67	57	9	3-19	.	.	.	160	4	2-10	98	1	1-12	18	0	0-99	83	2	2-13	107	1	0-7
DOCTDRS HDSP DF MOBILE INC MOBILE AL 36604	3	33	2-83	6	50	5-70	14	7	1-38	3	0	0-100	104	1	1-10	55	0	0-17	5	0	0-100	47	4	1-17	49	2	0-18
EAST ALABAMA MEDICAL CENTE OPELIKA AL 36802	35	17	10-46	17	29	12-56	73	8	4-19	10	0	0-100	256	4	3-9	112	4	2-13	19	5	0-80	170	3	2-9	138	0	0-6
EDGE MEM HDSP TRDY AL 36081	13	23	5-54	4	0	5-79	9	0	1-50	1	0	0-100	131	4	2-10	20	0	2-32	3	0	0-100	93	1	2-11	32	0	0-22
ELBA GENERAL HOSP- ELBA AL 36323	2	50	3-91	8	38	11-71	1	0	0-100	.	.	.	13	0	0-41	3	0	0-92	.	.	.	14	7	0-37	9	0	0-91
ELIZA COFFEE MEMORIAL HDSP FLDRENCE AL 35631	15	7	6-53	10	20	16-72	59	8	4-21	9	0	0-100	246	5	2-8	143	3	1-11	18	0	0-95	297	5	3-8	150	0	0-6
ELMDRE CO HOSP WETUMPKA AL 36092	2	0	0-91	4	0	4-78	5	0	0-70	.	.	.	46	11	1-16	17	6	0-35	2	0	0-100	38	3	1-18	20	0	0-38
ENTERPRISE HOSP ENTERPRISE AL 36331	9	22	3-58	2	0	4-92	2	0	1-89	.	.	.	32	13	1-21	15	0	1-36	1	0	0-100	29	3	1-23	9	0	0-86
EVERGREEN HOSP EVERGREEN AL 36401	24	17	11-52	4	50	7-82	.	.	.	.	.	.	30	7	1-22	7	0	0-60	.	.	.	42	5	2-19	11	0	0-58
EYE FOUNDATION HDSP- BIRMINGHAM AL 35233	.	.	.	.	.	.	.	.	.	227	0	0-4	.	.	.	.	.	.	.	.	.	.	.	.	6	0	0-95
FAYETTE CO HDSP FAYETTE AL 35555	17	12	6-50	6	0	10-76	2	0	0-98	.	.	.	53	2	1-15	4	0	0-80	1	0	0-100	48	2	1-15	16	0	0-57
FLDRALA MEMORIAL HDSP FLDRALA AL 36442	.	.	.	.	.	.	.	.	.	.	.	.	9	0	0-53	1	0	0-100	.	.	.	26	4	1-24	2	0	0-100
FLDWERS HOSP INC DOTHAN AL 36301	16	19	11-59	6	50	13-80	60	8	4-20	13	8	0-95	223	2	3-10	95	0	1-13	23	0	0-75	359	4	3-8	177	0	0-5
GEDRGE H LANIER MEM HDSP LANGDALE AL 36864	5	60	5-75	11	27	15-69	29	0	2-26	7	0	0-100	152	5	3-12	76	4	2-16	11	0	0-100	116	3	2-10	56	0	0-12

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		High Risk Diagnostic Categories																							
		Overall			Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
GEORGIANA DOCTORS HOSP GEORGIANA AL 36033	AL-65 *	182	12	8-20	2	100	3-91	2	50	1-89	2	0	0-94	8	13	4-59	12	0	15-66	1	0	0-100	38	18	9-35
GREENE CO HOSP EUTAW AL 35462	AL-66 *	80	11	6-22	1	100	0-99	4	25	4-77	3	0	1-81	5	20	3-69				6	0	1-63	12	25	5-51
GREENLAWN HOSP ATMORE AL 36502	AL-67 *	283	18	10-20	11	36	9-59	17	35	13-56	11	9	4-51	16	31	8-48	14	50	22-71	16	25	3-42	42	21	9-34
GROVE HILL MEMORIAL HOSP GROVE HILL AL 36451	AL-68 *	283	17	10-20	19	68	15-56	7	43	8-69	9	33	5-58	16	25	10-52	14	43	18-66	19	5	3-39	27	30	8-39
GUIN HOSP GUIN AL 35563	AL-69 *	86	7	4-19	3	67	3-83	1	0	0-97	2	0	1-89	5	40	3-70	4	25	6-81				10	10	3-52
GUNTERSVILLE HOSP GUNTERSVILLE AL 35976	AL-70	513	13	8-16	26	35	10-44	25	44	13-48	12	25	4-50	38	32	10-36	14	43	16-63	15	7	5-47	66	11	7-26
HALE CO HOSP GREENSBORO AL 36744	AL-71 *	166	15	11-24	8	63	7-64	16	38	16-60	1	0	0-99	12	8	8-55	6	33	13-79	8	25	5-61	21	24	10-46
HARTSELLE MEDICAL CENTER HARTSELLE AL 35640	AL-72	865	12	10-17	24	25	15-52	36	31	19-49	10	20	2-50	80	20	15-34	23	52	21-60	33	39	11-43	127	17	13-29
HCA ANDALUSIA HOSPITAL AUDALUSIA AL 36420	AL-73 *	667	12	8-15	24	46	9-44	28	32	15-49	16	19	5-44	24	17	9-42	22	45	21-60	18	0	4-41	88	23	11-29
HELEN KELLER MEMORIAL HOSP SHEFFIELD AL 35660	AL-74	1176	11	8-15	61	31	15-40	47	26	19-45	26	12	5-36	64	19	14-35	24	42	23-61	49	16	8-33	115	17	11-28
HENRY CO HOSP AND NH ABBEVILLE AL 36310	AL-75 *	170	16	7-19	3	0	1-81	4	25	2-75	2	0	0-92	13	46	8-53	3	100	10-92	16	13	4-44	24	17	7-39
HOLY NAME OF JESUS HOSP- GADSDEN AL 35902	AL-76 *	1887	11	9-15	93	14	13-33	69	19	17-39	36	8	6-33	108	25	15-31	82	38	27-49	47	28	12-39	223	20	14-27
HUMANA HOSP E MONTGOMERY MONTGOMERY AL 36193	AL-77	677	9	7-14	33	36	15-47	17	24	10-50	18	0	4-40	21	19	8-43	14	57	18-66	18	17	5-42	42	19	9-34
HUMANA HOSP ENTERPRISE ENTERPRISE AL 36330	AL-78	626	9	8-16	19	26	10-49	18	28	13-54	10	40	8-60	24	17	10-43	11	55	18-72	17	12	13-56	71	14	11-31
HUMANA HOSP FLORENCE FLORENCE AL 35630	AL-79	895	10	9-16	39	28	16-46	37	24	15-43	25	20	6-37	59	12	15-37	27	52	24-61	25	28	9-43	95	15	12-30
HUMANA HOSP RUSSELLVILLE RUSSELLVILLE AL 35653	AL-80	740	11	7-15	31	23	15-48	25	24	12-46	6	33	2-64	36	33	11-38	20	30	22-64	23	17	7-41	78	26	12-31
HUMANA HOSP SHOALS MUSCLE SHOALS AL 35661	AL-81 *	649	10	8-15	53	30	16-42	29	21	14-47	12	0	3-47	22	14	9-43	4	50	13-89	19	26	7-46	61	16	11-33
HUMANA HOSPITAL HUNTSVILLE HUNTSVILLE AL 35801	AL-82	2008	10	9-15	169	18	17-34	80	19	19-40	39	10	6-31	70	24	13-33	53	40	26-53	67	24	13-37	188	16	14-27
HUNTSVILLE HOSP HUNTSVILLE AL 35801	AL-83	2963	12	9-15	225	31	23-39	115	33	18-36	37	27	8-36	131	20	16-31	89	45	27-48	118	15	12-32	161	24	13-28
J PAUL JONES HOSP CAMDEN AL 36726	AL-84 *	177	16	9-22	6	83	11-78	9	33	8-63	5	40	2-68	14	36	9-54	7	0	12-75	4	25	5-80	23	26	9-43
JACKSON CO HOSP SCOTTSBORO AL 35768	AL-85 *	905	13	9-17	36	31	11-40	35	31	15-45	17	18	4-41	45	29	13-38	58	29	26-52	62	26	11-35	100	25	14-31
JACKSON HOSP- CLINIC INC MONTGOMERY AL 36106	AL-86 *	2845	10	9-15	216	25	20-36	98	32	20-39	68	15	13-35	106	17	14-31	48	35	28-56	98	12	10-31	229	23	14-27
JACKSONVILLE HOSP JACKSONVILLE AL 36265	AL-87 *	423	12	7-16	14	36	10-56	17	12	12-54	5	0	1-68	20	35	9-46	9	67	15-72	29	28	11-45	43	9	7-31
JOHN A ANDREW COMMUNITY HO TUSKEGEE INSTITUTE AL 36088	AL-88 *	156	17	6-17	7	43	3-61	8	25	7-64	5	20	1-68	5	20	2-68	3	67	4-85	18	22	6-44	10	20	5-54
KNOLLWOOD PARK HOSPITAL MOBILE AL 36609	AL-89	636	10	7-14	27	22	10-42	13	23	10-56	13	31	4-47	30	27	10-40	23	52	21-60	19	11	6-44	72	15	9-28
L V STABLER MEMORIAL HOSP GREENVILLE AL 36037	AL-90 *	627	11	9-16	26	31	17-53	27	30	14-47	19	21	6-43	33	36	13-43	22	41	23-63	12	17	9-58	55	16	9-31

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

AL-6

HOSPITALS	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
Name/ Location																											
GEORGIANA DOCTORS HOSP GEORGIANA AL 36033	12	25	7-57	1	0	0-97	1	0	0-98	1	0	0-100	22	0	1-27	2	0	0-98	4	0	0-100	14	0	0-39	4	0	0-96
GREENE CO HOSP EUTAW AL 35462	.	.	.	3	33	3-83	.	.	.	.	.	.	4	25	1-74	4	25	1-74	.	.	.	10	0	0-47	2	0	0-100
GREENLAWN HOSP ATMORE AL 36502	7	14	2-63	4	100	11-87	8	25	1-53	.	.	.	33	0	1-20	7	29	1-58	.	.	.	19	5	0-30	7	0	0-97
GROVE HILL MEMORIAL HOSP GROVE HILL AL 36451	8	25	8-68	3	67	7-89	4	25	1-74	.	.	.	32	0	1-20	20	10	3-35	4	0	0-100	28	4	1-22	6	0	0-99
GUIN HOSP GUIN AL 35563	1	0	0-99	.	.	.	1	0	0-100	.	.	.	4	0	0-85	.	.	.	1	0	0-100	17	0	0-33	5	0	0-93
GUNTERSVILLE HOSP GUNTERSVILLE AL 35976	8	0	2-60	5	60	9-80	.	.	.	.	.	.	56	7	1-15	25	12	1-27	5	0	0-100	59	3	2-15	21	0	0-44
HALE CO HOSP GREENSBORO AL 36744	7	14	3-64	3	0	5-86	.	.	.	.	.	.	13	8	0-40	5	0	0-81	.	.	.	13	0	0-40	3	0	0-95
HARTSELLE MEDICAL CENTER HARTSELLE AL 35640	6	0	5-70	6	33	8-74	22	0	3-32	.	.	.	85	6	2-14	52	10	2-18	11	0	0-71	106	3	2-11	41	0	0-17
HCA ANDALUSIA HOSPITAL AUDALUSIA AL 36420	8	13	3-61	7	14	9-71	21	10	2-31	.	.	.	95	4	2-12	24	0	0-27	1	0	0-100	97	3	2-11	33	3	0-21
HELEN KELLER MEMORIAL HOSP SHEFFIELD AL 35660	25	32	8-47	14	36	19-68	39	8	3-23	.	.	.	137	2	2-10	64	6	1-15	12	0	0-97	102	5	2-12	71	0	0-12
HENRY CO HOSP AND NH ABBEVILLE AL 36310	3	100	5-86	3	100	3-84	.	.	.	.	.	.	8	13	0-63	16	6	2-36	.	.	.	20	5	0-28	1	0	0-100
HOLY NAME OF JESUS HOSP- GADSDEN AL 35902	22	18	10-51	10	40	15-71	53	9	2-18	4	0	0-100	220	5	2-9	77	4	2-15	25	0	0-58	221	3	2-8	65	2	0-12
HUMANA HOSP E MONTGOMERY MONTGOMERY AL 36193	11	9	7-60	8	63	16-77	40	5	3-23	3	0	0-100	58	2	2-15	22	5	0-28	9	0	0-80	46	2	1-17	103	0	0-8
HUMANA HOSP ENTERPRISE ENTERPRISE AL 36330	16	19	7-52	11	18	11-63	18	0	2-34	2	0	0-100	70	1	2-14	50	0	1-17	13	0	0-78	77	5	2-12	22	0	0-34
HUMANA HOSP FLORENCE FLORENCE AL 35630	20	5	5-47	5	0	9-79	24	8	2-29	3	0	0-100	61	0	1-14	51	4	1-17	10	0	0-98	94	3	2-12	65	2	0-11
HUMANA HOSP RUSSELLVILLE RUSSELLVILLE AL 35653	6	17	2-67	9	22	13-70	9	0	1-50	.	.	.	101	4	1-11	25	12	0-26	6	0	0-100	72	3	1-13	49	0	0-15
HUMANA HOSP SHOALS MUSCLE SHOALS AL 35661	7	57	6-68	7	43	10-73	27	4	1-26	.	.	.	67	9	3-16	30	7	0-24	3	0	0-100	40	0	1-18	59	2	0-13
HUMANA HOSPITAL HUNTSVILLE HUNTSVILLE AL 35801	22	0	6-46	25	32	25-64	74	14	3-17	27	0	0-60	212	2	2-9	99	5	1-13	33	0	0-59	136	7	2-10	178	1	0-5
HUNTSVILLE HOSP HUNTSVILLE AL 35801	25	8	5-43	38	53	25-58	101	11	4-17	4	0	0-100	230	4	3-10	87	2	1-13	16	0	0-81	322	4	3-9	236	1	0-5
J PAUL JONES HOSP CAMDEN AL 36726	3	67	7-88	1	0	1-97	1	0	0-99	.	.	.	16	0	1-34	6	33	1-62	.	.	.	26	0	1-23	1	0	0-100
JACKSON CO HOSP SCOTTSBORO AL 35768	9	44	5-61	3	33	4-85	24	4	2-29	1	0	0-100	98	4	1-11	38	5	1-20	12	0	0-100	102	0	1-10	37	3	0-20
JACKSON HOSP- CLINIC INC MONTGOMERY AL 36106	28	11	9-47	32	50	28-63	77	12	4-18	15	0	0-99	233	3	3-10	155	6	2-11	19	0	0-98	225	6	3-9	229	1	0-5
JACKSONVILLE HOSP JACKSONVILLE AL 36265	1	0	0-99	1	0	0-97	7	43	2-58	.	.	.	41	10	1-17	51	12	1-17	6	0	0-95	37	5	1-19	14	0	0-81
JOHN A ANDREW COMMUNITY HO TUSKEGEE INSTITUTE AL 36088	2	100	3-91	1	0	0-97	2	0	0-92	19	0	0-78	13	8	1-39	1	0	0-100	.	.	.	10	20	0-49	6	17	0-99
KNOLLWOOD PARK HOSPITAL MOBILE AL 36609	6	17	3-68	5	20	3-71	29	3	2-25	1	0	0-100	70	10	1-13	39	5	1-20	1	0	0-100	46	0	1-16	58	2	0-16
L V STABLER MEMORIAL HOSP GREENVILLE AL 36037	12	8	8-59	5	20	9-80	11	0	1-44	1	0	0-100	71	0	1-13	18	0	1-32	7	0	0-99	51	6	1-15	28	0	0-29

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		High Risk Diagnostic Categories																							
		Overall			Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
LAKESHORE COMMUNITY HOSP OADEVILLE AL 36853	AL-91	244	12	7-17	9	56	13-70	11	9	8-57	5	60	2-69	11	18	5-51	7	29	8-70	9	0	1-53	39	18	8-33
LAKEVIEW COMMUNITY HOSP EUFULA AL 36027	AL-92 *	536	15	8-16	13	46	9-56	10	10	6-56	17	24	3-40	30	23	11-42	13	85	19-69	13	31	5-50	70	24	11-32
LAMAR REGIONAL HOSP VERNON AL 35592	AL-93 *	373	13	10-19	10	70	19-74	9	33	8-62	2	0	0-90	16	19	7-46	11	36	18-71	18	28	8-48	67	22	13-35
LAWRENCE CO HOSP MOULTON AL 35650	AL-94 *	515	10	9-17	13	31	11-59	20	35	12-50	16	13	5-44	24	17	12-47	27	41	27-63	11	9	3-49	92	10	9-27
LIVINGSTON TOMBIGBEE LIVINGSTON AL 35470	AL-95 *	115	6	3-15	1	0	0-97	2	50	5-93	3	0	0-82	5	20	2-68				2	0	0-91	8	13	3-56
LLOYD NOLANO HOSP FAIRFELD AL 35064	AL-96	2135	12	9-16	149	22	15-33	106	25	19-38	36	22	8-35	105	16	16-33	80	39	28-50	78	27	11-33	202	28	15-29
LONGVIEW GENERAL HOSP GRAYSVILLE AL 35073	AL-97 *	235	11	9-19	8	63	12-71	15	20	11-55	8	25	2-56	13	23	7-52	2	100	6-95	14	14	4-47	35	14	10-38
MARION CO GENERAL HOSP HAMILTON AL 35570	AL-98	323	13	9-18	11	73	17-70	13	31	13-61	2	0	0-93	15	13	6-47	20	75	26-67	8	13	7-65	25	16	9-42
MEOICAL CENTER EAST BIRMINGHAM AL 35235	AL-99	2590	12	9-15	175	31	16-32	70	30	18-40	45	13	7-32	135	23	15-30	124	29	28-47	63	21	12-36	199	23	15-28
MEDICAL PARK WEST BIRMINGHAM AL 35218	AL-100*	242	12	8-19	5	60	1-68	10	0	6-56	4	25	5-78	28	7	9-39	4	0	8-83	9	0	2-54	43	23	12-38
MIZELL MEMORIAL HOSPITAL OPP AL 36467	AL-101*	691	10	7-15	27	59	19-55	32	25	16-47	11	27	5-52	34	9	11-39	12	58	17-69	18	11	5-43	88	13	10-27
MOBILE INFIRMARY ROTARY RE MOBILE AL 36652	AL-102	5988	9	8-14	505	18	17-31	226	18	21-35	117	15	11-28	233	24	17-29	202	32	29-45	130	10	9-27	424	17	15-26
MONROE CO HOSP MONROEVILLE AL 36460	AL-103*	633	13	9-17	27	52	22-58	30	43	14-47	19	11	5-40	52	21	12-35	15	60	22-69	32	25	7-37	65	12	10-30
NORTH BALOWIN HOSP BAY MINETTE AL 36507	AL-104*	247	10	7-17	10	20	7-59	7	14	8-69	6	0	3-64	14	7	5-47	13	46	17-66	6	33	5-68	26	8	6-35
NORTH JACKSON HOSP BRIDGEPORT AL 35740	AL-105	243	13	8-19	11	55	8-58	4	0	3-77	2	0	1-89	8	25	4-58	23	39	20-59	5	20	3-70	29	17	8-38
NORTH MOBILE COMMUNITY HOS SATSUMA AL 36572	AL-106*	72	3	2-16										1	0	0-97				6	17	1-63	11	0	2-47
NORTHEAST ALABAMA REGIONAL ANNISTON AL 36202	AL-107*	2174	11	8-15	135	31	19-38	66	27	18-41	36	14	8-35	87	24	13-31	69	26	27-51	57	21	12-37	181	25	13-28
PARKWAY MEDICAL CENTER HOS OECATUR AL 35601	AL-108*	729	11	8-16	18	39	12-54	39	23	16-45	13	15	3-45	41	17	11-36	17	35	18-62	29	17	9-41	96	21	10-28
PERRY COMMUNITY HOSP MARION AL 36756	AL-109*	200	15	9-21	6	50	13-80	5	20	7-76	1	0	0-97	15	47	10-53	4	25	9-84	9	11	9-64	22	14	7-40
PHENIX MEOICAL PARK HOSP PHENIX CITY AL 36867	AL-110	1357	11	7-14	44	32	15-43	56	38	16-40	26	15	4-34	86	13	13-31	37	35	23-54	57	12	10-34	132	22	10-25
PICKENS CO MEOICAL CENTER CARROLLTON AL 35447	AL-111*	427	15	10-19	19	42	10-49	22	9	15-53	22	9	5-38	20	30	10-48	16	63	21-67	23	9	5-38	58	24	12-34
PIEOMONT HOSP PIEOMONT AL 36272	AL-112*	255	7	7-17	6	33	4-67	11	18	9-58	6	0	1-63	15	7	6-47	9	22	11-67	15	0	4-44	42	19	10-36
PROVIDENCE HOSP MOBILE AL 36604	AL-113	2129	13	10-16	143	31	19-37	97	32	20-39	76	14	10-31	119	13	15-31	52	35	26-53	70	23	10-33	207	20	13-27
RAN0OLPH CO HOSP ROANOKE AL 36274	AL-114*	421	18	11-20	8	50	5-61	34	38	19-50	13	8	4-46	29	38	10-41	20	25	20-61	16	31	8-50	60	23	12-34
REO BAY HOSP REO BAY AL 35582	AL-115*	311	12	10-19	6	67	9-75	19	11	10-49	6	0	8-73	13	31	7-52	12	58	21-73	10	40	11-65	41	22	12-38
RUSH HILL HOSP OF YORK YORK AL 36925	AL-116*	213	11	10-22	5	80	17-88	13	8	11-57	1	0	0-100	20	15	7-41	3	100	10-91	13	8	3-46	31	16	11-41

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

AL-8

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
LAKE SHORE COMMUNITY HOSP OAOEVILLE AL 36853				2	0	4-93	1	0	0-99				32	6	2-23	6	17	0-64				23	4	1-26	10	0	0-77
LAKEVIEW COMMUNITY HOSP EUFULA AL 36027	5	0	7-77	10	30	13-68	3	0	0-88				79	4	1-12	33	27	4-28	3	0	0-100	66	6	1-13	9	0	0-98
LAMAR REGIONAL HOSP VERNON AL 35592	6	17	7-73	12	33	14-66							38	3	1-19	16	13	1-35	2	0	0-100	75	1	2-13	3	0	0-100
LAWRENCE CO HOSP MOULTON AL 35650	9	11	5-61	1	0	1-97				1	0	0-100	48	2	1-16	21	5	2-31	1	0	0-100	76	4	2-13	15	0	0-61
LIVINGSTON TOMBIGBEE LIVINGSTON AL 35470	1	0	2-99										10	0	0-60	2	50	0-97				4	0	0-85	5	0	0-98
LLOYD NOLAND HOSP FAIRFIELD AL 35064	23	26	12-53	12	42	16-68	53	9	3-20	9	0	0-100	187	3	2-10	113	12	2-14	20	0	0-71	182	3	2-9	84	1	0-9
LONGVIEW GENERAL HOSP GRAYSVILLE AL 35073	3	0	0-83	4	0	7-83	5	0	0-71				26	4	1-24	3	33	1-81	2	0	0-100	33	3	1-20	14	0	0-76
MARION CO GENERAL HOSP HAMILTON AL 35570	1	100	0-97	4	0	5-79							41	5	1-18	15	0	1-36	1	0	0-100	46	0	1-17	14	0	0-64
MEICAL CENTER EAST BIRMINGHAM AL 35235	21	38	8-49	35	40	19-53	100	7	4-17	5	0	0-100	313	5	2-8	134	4	2-12	21	0	0-74	250	5	2-8	154	1	0-6
MEICAL PARK WEST BIRMINGHAM AL 35218	4	75	7-82	3	33	6-87							17	12	0-33	11	0	0-47				34	3	1-19	3	0	0-100
MIZELL MEMORIAL HOSPITAL OPP AL 36467	11	9	3-54	1	100	1-97	19	5	1-31				85	5	2-13	24	8	1-27	3	0	0-100	91	0	1-11	48	2	0-19
MOBILE INFIRMARY ROTARY RE MOBILE AL 36652	52	17	9-40	57	30	22-50	135	7	4-15	63	2	0-25	528	3	3-8	241	4	1-10	46	0	0-22	720	3	3-6	481	1	0-3
MONROE CO HOSP MONROEVILLE AL 36460	4	25	1-76	8	13	16-77	4	0	0-75				64	5	2-15	21	5	2-30	1	0	0-100	53	6	1-15	21	0	0-46
NORTH BALOWIN HOSP BAY MINETTE AL 36507	5	40	4-73	3	67	6-87	2	50	0-90				32	3	0-20	11	0	0-47	2	0	0-96	23	4	0-25	3	0	0-99
NORTH JACKSON HOSP BRIIDGEPORT AL 35740	4	50	7-83	1	0	2-98							31	6	1-21	5	0	0-75				29	0	1-22	11	9	0-87
NORTH MOBILE COMMUNITY HOS SATSUMA AL 36572	1	0	0-99										5	20	0-88	4	0	0-92				14	0	0-41	3	0	0-100
NORTHEAST ALABAMA REGIONAL ANNISTON AL 36202	29	21	5-42	3	33	5-86	98	7	4-17	2	0	0-100	210	3	2-9	118	11	4-15	23	0	0-94	245	4	3-9	126	2	0-7
PARKWAY MEDICAL CENTER HOS DECATUR AL 35601	8	13	4-63	3	33	8-89	8	0	1-54				85	5	2-12	48	8	2-19	3	0	0-93	54	2	2-15	46	0	0-19
PERRY COMMUNITY HOSP MARION AL 36756	5	20	2-71	2	100	4-92	2	0	0-97				24	0	1-26	11	18	1-45	1	0	0-100	26	8	2-26	2	0	0-100
PHENIX MEDICAL PARK HOSP PHENIX CITY AL 36867	22	36	9-51	11	36	10-62	23	0	1-28	2	0	0-100	167	2	2-9	46	4	1-18	5	0	0-100	134	4	1-8	70	0	0-12
PICKENS CO MEDICAL CENTER CARROLTON AL 35447	5	0	4-73	9	44	12-69							29	7	1-22	14	21	1-38	2	0	0-100	34	6	1-20	11	0	0-73
PIEDMONT HOSP PIEDMONT AL 36272	3	33	0-85	4	0	5-79		0	0-99				28	0	1-22		0	0-96		1		24	0	0-25		0	0-96
PROVIDENCE HOSP MOBILE AL 36604	40	20	8-42	14	50	17-65	44	0	2-21	15	0	0-96	241	0	3-10	99	0	2-14	18	0	0-96	143	0	2-11	87	1	0-9
RANDOLPH CO HOSP ROANOKE AL 36274	2	50	1-90	3	33	6-87	6	50	5-68				47	15	2-18	15	7	2-38	2	0	0-100	25	0	1-24	20	5	0-53
REO BAY HOSP REO BAY AL 35582	9	22	8-65				1	100	0-97				27	0	1-23	16	0	0-35	1	0	0-100	37	3	1-19	6	0	0-85
RUSH HILL HOSP OF YORK YORK AL 36925	6	0	5-70	5	20	12-83	2	0	0-97				11	0	0-44	6	17	1-62				28	4	1-23	1	0	0-100

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		High Risk Diagnostic Categories																									
		Overall			Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease				
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent		
Name/Location	Comment/Reference	RUSH HOSP BUTLER INC BUTLER AL 36904	AL-117*	279	8	9-18	9	56	11-68	7	57	9-71	1	0	0-98	31	3	10-39	3	67	8-89	14	7	6-50	58	9	11-34
RUSSELL HOSP ALEXANDER CITY AL 35010	AL-118*	634	14	10-17	38	34	11-39	36	31	17-47	13	15	6-51	37	16	13-41	23	48	20-59	21	19	8-45	69	19	11-31		
SELMA MEDICAL CTR HOSP SELMA AL 36701	AL-119*	1737	12	9-15	100	35	17-38	46	28	14-40	38	24	7-33	99	15	16-34	36	53	27-59	74	24	12-35	182	20	13-27		
SHELBY MEDICAL CENTER ALA8ASTER AL 35007	AL-120	1333	11	6-13	52	25	11-36	37	24	16-45	36	8	4-30	43	23	11-36	40	55	23-53	26	42	9-43	124	27	11-27		
SOUTH BALDWIN HOSP FOLEY AL 36535	AL-121*	824	12	9-16	45	36	11-38	32	38	16-48	16	25	5-43	25	20	10-44	39	41	28-59	19	26	7-45	106	18	13-31		
SOUTH HIGHLANDS HOSP- BIRMINGHAM AL 35205	AL-122	1073	9	6-13	67	18	13-36	26	23	15-49	15	13	4-44	37	14	10-36	29	48	25-60	18	11	4-42	91	18	9-27		
SOUTHEAST ALABAMA MEDICAL DOTHAN AL 36302	AL-123	3512	9	7-14	200	22	17-34	108	27	20-38	66	12	9-30	108	18	14-31	99	45	27-48	144	17	11-30	198	18	13-27		
SPRINGHILL MEMORIAL HOSP- MOBILE AL 36608	AL-124	1650	9	7-14	83	19	12-33	51	25	14-38	35	23	6-33	60	30	14-36	41	29	25-56	40	25	11-40	182	12	11-25		
ST CLAIR REGIONAL HOSP PELL CITY AL 35125	AL-125*	500	16	9-18	11	55	9-59	18	44	11-50	13	38	3-46	35	17	11-38	23	39	21-60	9	33	10-67	84	21	10-28		
ST MARGARETS HOSP MONTGOMERY AL 36104	AL-126*	2076	12	9-15	80	18	15-37	85	21	18-39	33	21	6-34	98	15	14-31	128	33	26-44	68	18	10-32	148	28	14-29		
ST VINCENTS HOSP BIRMINGHAM AL 35205	AL-127	2775	10	8-14	222	25	18-34	118	25	19-36	35	9	8-36	103	22	15-32	69	41	29-53	30	20	7-38	209	15	12-25		
STRINGFELLOW MEMORIAL HOSP ANNISTON AL 36201	AL-128	757	10	7-15	49	24	13-39	34	26	17-47	10	30	4-53	18	28	10-50	16	44	22-68	14	7	5-49	85	13	9-27		
SYLACAUGA HOSP SYLACAUGA AL 35150	AL-129	1135	11	8-15	59	32	14-38	49	24	17-43	35	9	3-29	47	11	11-35	46	50	25-53	50	14	7-32	124	13	10-25		
THOMAS HOSP FAIRHOPE AL 36532	AL-130*	836	10	7-15	60	25	13-37	21	38	12-50	20	5	5-40	56	29	13-35	23	30	18-56	26	15	7-40	62	16	11-33		
THOMASVILLE HOSP THOMASVILLE AL 36784	AL-131*	211	13	8-19	3	67	1-81	6	50	3-65	3	33	2-81	10	0	5-54	8	38	14-74	28	11	11-45	24	25	8-41		
UNIVERSITY OF ALABAMA HOSP BIRMINGHAM AL 35233	AL-132	4880	10	8-14	406	18	19-33	103	31	19-38	76	18	10-31	134	13	15-30	148	30	28-46	75	20	8-29	226	24	14-28		
UNIVERSITY OF SOUTH ALA ME MOBILE AL 36617	AL-133	1431	12	8-15	101	25	13-33	72	29	15-36	39	26	7-32	69	13	12-32	43	44	24-53	50	22	8-33	96	17	12-30		
US ARMY HOSP FORT MCLELLAN AL 36201	AL-134	1	0	0-100	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.		
US ARMY HOSP FORT RUCKER AL 36360	AL-135	1	100	0-100	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.		
VAUGHN REGIONAL MEDICAL CE SELMA AL 36701	AL-136	663	10	8-16	52	23	14-40	20	10	12-51	12	17	4-48	31	10	11-40	14	64	21-70	21	5	6-42	61	16	11-33		
WALKER REGIONAL MEDICAL CE JASPER AL 35501	AL-137*	2138	12	9-15	85	39	17-39	62	27	18-41	64	17	10-32	82	26	15-34	54	54	28-55	51	29	9-34	242	18	14-27		
WASHINGTON CO HOSP CHATOM AL 36518	AL-138*	124	11	8-22	1	100	1-98	6	17	7-72	1	0	0-99	8	13	6-62	1	0	1-97	10	10	5-55	32	22	8-37		
WEDOWEE HOSP CORP WEDOWEE AL 36278	AL-139*	99	8	6-21	4	25	6-81	4	25	3-76	3	0	1-82	5	20	5-73	4	75	5-79	3	0	1-81	13	8	4-46		
WINFIELD CARRAWAY HOSP WINFIELD AL 35594	AL-140*	428	13	8-16	9	44	4-55	9	22	9-64	4	25	2-75	17	47	9-48	12	33	18-70	18	50	10-51	57	18	10-32		
WIREGRASS HOSP GENEVA AL 36340	AL-141*	475	12	8-16	9	33	4-56	21	43	14-52	6	17	5-69	25	32	10-43	3	33	7-88	21	33	8-45	58	16	11-33		
WOODLAND COMMUNITY HOSP CULLMAN AL 35055	AL-142*	670	13	9-17	32	34	10-41	23	48	14-50	15	13	5-46	27	30	10-41	31	35	24-58	23	22	9-45	74	24	12-32		

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

AL-10

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
RUSH HOSP BUTLER INC BUTLER AL 36904	2	0	0-94	1	0	2-98	.	.	.	.	.	.	27	0	0-23	15	7	1-36	.	.	.	39	0	1-18	6	0	0-95
RUSSELL HOSP ALEXANDER CITY AL 35010	9	33	5-62	6	33	6-71	11	18	1-44	4	0	0-100	76	9	3-15	32	6	1-22	1	0	0-100	50	10	2-17	11	0	0-90
SELMA MEDICAL CTR HOSP SELMA AL 36701	27	11	8-46	33	33	20-54	40	10	3-23	8	0	0-100	191	3	3-10	103	3	2-14	11	0	0-100	145	1	2-10	82	0	0-9
SHELBY MEDICAL CENTER ALABASTER AL 35007	17	24	6-50	13	38	13-62	34	6	2-23	.	.	.	93	6	1-11	118	1	1-12	38	0	0-42	135	3	2-9	121	1	0-7
SOUTH BALDWIN HOSP FOLEY AL 36535	13	8	6-54	10	40	10-64	22	5	1-29	.	.	.	106	3	1-10	29	7	1-24	5	0	0-100	113	2	2-10	29	3	0-31
SOUTH HIGHLANDS HOSP-BIRMINGHAM AL 35205	10	50	7-62	5	20	13-84	26	4	2-27	17	0	0-69	145	5	2-10	62	3	1-15	10	0	0-100	62	3	1-13	135	0	0-7
SOUTHEAST ALABAMA MEDICAL OOTHAN AL 36302	37	27	12-47	42	38	26-58	98	9	4-17	48	0	0-31	365	4	2-8	206	3	1-10	32	3	0-44	370	5	3-7	226	0	0-5
SPRINGHILL MEMORIAL HOSP-MOBILE AL 36608	15	13	5-51	17	24	15-59	58	3	4-21	5	0	0-100	177	7	3-10	74	3	1-14	24	0	0-41	123	7	1-9	107	1	0-7
ST CLAIR REGIONAL HOSP PELL CITY AL 35125	11	9	9-62	9	56	11-68	6	0	0-70	.	.	.	58	5	1-14	17	6	2-35	3	0	0-100	64	5	1-13	16	0	0-66
ST MARGARETS HOSP MONTGOMERY AL 36104	21	14	5-45	20	65	23-66	35	17	2-22	52	0	0-28	185	6	2-10	63	5	2-16	9	0	0-89	362	6	3-8	69	1	0-11
ST VINCENTS HOSP BIRMINGHAM AL 35205	28	7	9-47	13	38	17-67	72	10	3-17	2	0	0-100	327	6	3-9	134	5	2-12	48	2	0-17	215	7	2-8	274	0	0-4
STRINGFELLOW MEMORIAL HOSP ANNISTON AL 36201	14	14	6-54	2	0	1-89	.	.	.	20	0	0-88	110	6	2-12	88	10	1-13	6	0	0-99	61	2	2-15	21	5	0-34
SYLACAUGA HOSP SYLACAUGA AL 35150	12	25	5-56	20	25	17-58	31	10	1-24	6	0	0-100	119	3	1-10	65	5	1-15	13	0	0-59	96	3	1-11	40	3	0-20
THOMAS HOSP FAIRHOPE AL 36532	5	20	3-72	10	20	10-64	36	6	2-22	2	0	0-100	110	4	2-11	52	6	1-17	12	0	0-100	50	4	1-15	84	0	0-9
THOMASVILLE HOSP THOMASVILLE AL 36784	1	0	0-97	1	0	0-97	4	50	1-74	.	.	.	18	6	1-31	7	0	1-58	1	0	0-100	20	0	1-28	9	0	0-92
UNIVERSITY OF ALABAMA HOSP BIRMINGHAM AL 35233	107	12	6-33	44	43	23-54	62	18	6-23	8	0	0-100	201	8	4-11	100	6	2-14	19	0	0-57	777	6	4-7	299	3	0-4
UNIVERSITY OF SOUTH ALA ME MOBILE AL 36617	32	16	11-47	13	46	12-61	48	8	3-21	9	0	0-96	87	9	2-13	33	6	1-22	5	20	0-100	120	7	2-10	51	2	0-13
US ARMY HOSP FORT MCCLELLAN AL 36201	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	
US ARMY HOSP FORT RUCKER AL 36360	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	
VAUGHN REGIONAL MEDICAL CE SELMA AL 36701	8	13	4-62	10	40	13-68	10	20	2-48	9	0	0-99	71	3	2-14	38	5	1-21	4	0	0-100	58	5	2-15	32	0	0-23
WALKER REGIONAL MEDICAL CE JASPER AL 35501	36	17	8-43	47	38	24-55	39	8	2-22	1	0	0-100	226	4	3-9	100	7	2-14	28	0	0-60	203	6	3-9	107	0	0-7
WASHINGTON CO HOSP CHATOM AL 36518	2	0	0-90	1	0	0-97	.	.	.	.	.	.	12	17	1-41	1	0	0-98	.	.	.	24	0	1-25	1	0	0-100
WEDOWEE HOSP CORP WEDOWEE AL 36278	1	0	1-97	.	.	.	.	.	.	.	.	.	8	0	1-53	1	0	0-99	.	.	.	7	0	0-60	4	0	0-99
WINFIELD CARRAWAY HOSP WINFIELD AL 35594	8	13	5-63	7	29	12-75	9	22	2-52	1	0	0-100	65	6	1-13	12	17	1-42	4	0	0-100	56	7	1-15	17	0	0-48
WIREGRASS HOSP GENEVA AL 36340	22	9	6-46	8	13	12-72	1	0	0-100	.	.	.	54	2	1-15	27	0	1-25	2	0	0-100	64	8	2-14	12	0	0-95
WOODLAND COMMUNITY HOSP CULLMAN AL 35055	8	38	4-62	8	50	13-73	18	0	2-34	1	0	0-100	91	3	1-12	59	7	2-18	.	.	.	71	3	2-13	24	0	0-31

*Written Comments Not Submitted.



Gregory H. Burfitt
President and Chief Executive Officer

October 26, 1987

Department of Health & Human Services
Health Care Financing Administration
The Administrator
Washington, D.C. 20201

Dear Sir:

Attached is a list of comments and corrections to the HCFA mortality data as supplied to AMI Brookwood Medical Center in September, 1987.

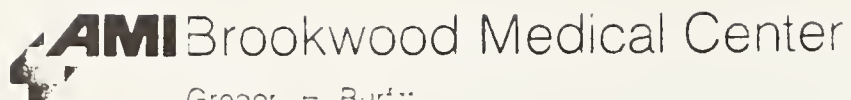
We appreciate the opportunity to review and correct this information so that the documents to be published in December will reflect the most accurate information available.

Sincerely,

A handwritten signature in cursive script that reads 'Gregory Burfitt'.

Gregory H. Burfitt
President & CEO

GHB/ph



Gregory, — Burfit
President and Chief Executive Officer

HCFA MORTALITY REVIEW Corrections to Data

DEATHS AT ANOTHER HOSPITAL

██████████	██████████	CA	067	M	11-04-86	11-09-86	11-30-86 (11-27-86)
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CORRECTION OF DISCHARGE/DEATH DATES

██████████	██████████	CA	086	M	06-23-86	06-28-86	06-27-86 (06-28-86)
██████████	██████████	CA	063	F	08-05-86	08-09-86	08-08-86 (08-09-86)
██████████	██████████	CA	079	M	02-23-86	03-11-86	03-10-86 (03-11-86)
██████████	██████████	CA	069	M	02-13-86	02-21-86	02-22-86 (02-21-86)
██████████	██████████	HS	076	M	02-25-86	02-27-86	02-28-86 (02-27-86)
██████████	██████████	HS	062	F	07-06-86	07-09-86 (07-08-86)	07-09-86 (07-08-86)
██████████	██████████	HS	076	M	10-21-86	10-26-86 (10-25-86)	10-26-86 (10-25-86)

CORRECTION OF ADMISSION DATES

[REDACTED]	[REDACTED]	UN	070	F	01-02-86 (01-09-86)	01-08-86 (01-25-86)	01-24-86 (01-25-86)
[REDACTED]	[REDACTED]	CA	072	M	12-08-86 (12-26-86)	12-24-86 (01-03-87)	01-03-87
[REDACTED]	[REDACTED]	CA	070	M	12-22-86 (12-29-86)	12-24-86 (01-07-87)	01-07-87
[REDACTED]	[REDACTED]	GI	072	F	12-19-86 (01-08-87)	12-24-86 (01-12-87)	01-12-87
[REDACTED]	[REDACTED]	UN	061	M	12-26-86 (01-02-87)	12-30-86 (01-09-87)	01-09-87

CORRECTION TO AGE

[REDACTED]	[REDACTED]	CA	068 (072)
[REDACTED]	[REDACTED]	CA	079 (080)
[REDACTED]	[REDACTED]	CA	075 (074)
[REDACTED]	[REDACTED]	CA	084 (083)
[REDACTED]	[REDACTED]	HS	068 (073)
[REDACTED]	[REDACTED]	HS	070 (065)
[REDACTED]	[REDACTED]	ME	057 (056)
[REDACTED]	[REDACTED]	PN	090 (086)

[REDACTED]	[REDACTED]	PN	088 (087)
[REDACTED]	[REDACTED]	PN	064 (063)
[REDACTED]	[REDACTED]	UN	078 (073)
[REDACTED]	[REDACTED]	UN	080 (081)
[REDACTED]	[REDACTED]	UN	093 (086)

QUESTIONABLE DIAGNOSTIC CATEGORY

[REDACTED]	[REDACTED]	CA (HM)
------------	------------	------------

The patient had adenocarcinoma of the prostate with multiple metastasis x 8 years. Underwent TURP to relieve bleeding. Had a sudden heart attack 3 days post operatively. (Died in hospital)

[REDACTED]	[REDACTED]	CA (CE)
------------	------------	------------

The patient had transitional cell carcinoma of right ureter. He had significant history of severe vascular disease. He was being treated with coumadin for ischemic vascular disease. He was considered a high surgery risk. He did not regain consciousness post-operatively. CT revealed cerebral infarction.

[REDACTED]	[REDACTED]	OP (CA)
------------	------------	------------

The patient had histiocytic lymphoma of the transverse colon. Admitted for severe low back pain not controlled by medications at home. (Died in hospital)

[REDACTED] [REDACTED] OP
(HM)

The patient had a history of several chronic heart and lung conditions i.e., congestive heart failure, severe ischemic heart disease chronic obstructive pulmonary disease, acute pulmonary edema. Admitted for infected foot ulcer with debridement and amputation of 4th digit left foot. (Died 3 days post discharge)

[REDACTED] [REDACTED] OP
(CA)

The patient had lung carcinoma with bony metastases. Admitted for pathologic fracture left humerus, and left hip secondary to carcinoma. (Died 7 days post discharge at home)

[REDACTED] [REDACTED] GYN
(CA)

The patient was admitted for D&C for post-menopausal bleeding. The patient was being worked up for suspected metastatic carcinoma based on presence of new lung nodules. (Died outside hospital 29 days post discharge - CA unconfirmed)

[REDACTED] [REDACTED] TR
(CE)

Patient fell at home and fractured right hip. The patient fell because she became weak and passed out with questionable loss of consciousness. She had a history of coronary artery disease. Patient was taken to operating room but experienced a drop in blood pressure that could not be increased. She died in surgery.

COMMENTS

1. AMI Brookwood Medical Center, Medical Staff Quality Assurance Committees perform a monthly review of all hospital deaths for quality and appropriateness of care.
2. The UHDDS definition for principal diagnosis used by HCFA "condition established after study to be chiefly responsible for occasioning admission to the Hospital" caused some cases to be credited to an incorrect diagnostic category.
Example: Patient with diagnosis of lung carcinoma with bony metastases admitted with pathologic fracture of hip secondary to carcinoma grouped to orthopedic category instead of the appropriate cancer category.

The AMI Brookwood trauma category included a significant number of cases with principal diagnosis of fracture, when in fact, the patients died from complicating causes such as chronic obstructive pulmonary disease, end stage aortic stenosis, diabetes mellitus.

It is evident that while assigning a principal diagnosis for classification to a DRG payment system may be acceptable for reimbursement it is inadequate for qualifying causes of death. To provide a comprehensive review, all complications and co-existing diseases must be included in the review to explain or group deaths.

3. The average age of the 309 deaths listed for AMI Brookwood was 75.
4. By including deaths thirty days after discharge, the Hospital has no accurate method of determining cause of death or care delivered following patient discharge. Of the 309 deaths verified as both in hospital and 30 days after discharge, 50 or 16% did not die in the Hospital.
5. Of the 259 deaths verified as in hospital deaths, 46 or 18% died within 24 hours of admission, indicating the patient's acute state on admission.
6. All deaths listed on the HCFA mortality information were reviewed for accuracy. The following errors were identified and submitted to HCFA as corrections:
one death credited to AMI Brookwood that occurred at another Hospital, seven (7) incorrect discharge/death dates, five (5) incorrect admissions and thirteen (13) age discrepancies.

After a thorough review of all death cases, recommendations were also made to change the diagnostic category for seven (7) cases.

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
P. O. Box 26684
Baltimore, Maryland 21207

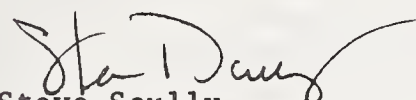
Dear Dr. Roper:

The comments on the HCFA Mortality Data is submitted as requested in your letter of September 21, 1987.

These comments are submitted following a detailed review of each line of data provided.

Thank you for the opportunity to review and give clarification of data with these comments.

Sincerely,


Steve Scully
President/CEO

SS/smj

COMMENTS ON THE HCFA MORTALITY DATA
AMI West Alabama Hospital, Northport, Alabama

Medicare Provider # 01-0145

Date Verification

The HCFA data supplied listing cases by diagnostic category totals 1954 Medicare cases for AMI West Alabama Hospital. Hospital data indicates 1929 Medicare cases for the same period (1986). This reflects a difference of 25 total Medicare admissions. Presumably this discrepancy reflects additional admissions to another hospital.

The HCFA listing of Medicare patients admitted to this facility indicates a total of 133 deaths within 30 days of admission. Each patient listed on the HCFA report of deaths was verified with a hospital list to determine status of discharge information. Only 105 of these died while in the hospital, with the other 28 recorded as being discharged alive. It is impossible for our hospital to verify any information or percentages relative to the 28 patients listed as dying after discharge. These 28 deaths post-discharge represents 21% of HCFA's listed deaths or 1.4% of total Medicare admissions.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic on other data used in your analysis.

Interpretive Remarks

The hospital's actual mortality rate does not fall outside of the range of the predicted mortality rate in any (none) of the diagnostic categories. After correcting the errors in the recording of deaths, the number of categories in which the actual mortality rate is outside the range of the predicted mortality rate remains 0.

Unique Services Resulting in Higher than Average Mortality

AMI West Alabama Hospital has an acute care contract with state hospitals in the Tuscaloosa area.

Alice Kid Intermediate Care Facility - Nursing home type of facility for long-term intermediate care of life committed patients in the state mental health system. A total of 216 beds are available for occupancy.*

S.D. Allen Intermediate Care Facility - Nursing home type of facility for long-term intermediate care of life committed patients in the state mental health system. A total of 138 beds are available for occupancy.*

Bryce Hospital - Psychiatric facility with both acute and chronic (life commitment) residents. A total of 1037 beds are available for occupancy. *

Taylor-Hardin Secure Medical Facility - Secure medical facility for state prisoners. *

*Figures provided by these facilities.

Due to the mental disorders involved in these patients, the severity of illness at time of admission is higher than might otherwise be expected. (These patient seem less able to recognize and/or communication early symptoms.) Patients' cooperation with care and understanding of patient testing is limited during acute care treatment, complicating and prolonging course of illness. Thirty-five of the 105 deaths in the hospital occurred in this group.

Another unique area of service is the nursing home population in the Tuscaloosa area. Of the six nursing homes in Tuscaloosa County, five are within a two mile radius of AMI West Alabama Hospital. There are also several nursing homes in adjacent counties who routinely admit to this hospital. (Note, of the 105 deaths listed in-house, sixteen were from nursing homes.)

With the exclusion of the 51 patients from high mortality populations outlined above, the in-hospital death numbers would be 54 patients.

There were twenty-four deaths in the hospital emergency room with five of these patients being transferred from nursing homes and five being transferred from Bryce Hospital.

ARAB HOSPITAL

ARAB, ALABAMA
35016

October 23, 1987

ID # 010010

JESSE G. BROWN
ADMINISTRATOR

COMMENTS ON THE HCFA MORTALITY DATA

DATA VERIFICATION

The data used by HCFA indicate that a total of 41 Medicare patients admitted to Arab Hospital died within 30 days of admission. Of these, 32 died while still a patient of the hospital, while 09 died after discharge. Our own records indicate that 553 Medicare admissions occurred in 1986. Our own records also indicate that of the 41 Medicare patients who died within 30 days of discharge while still an inpatient, 09 were still alive at the time of discharge. The HCFA analysis indicates 340 cases reviewed in 1986.

The data HCFA submitted indicated 11 patients died within 30 days after discharge of the patient from the hospital, of the 11 patients who died after leaving the hospital it was noted after medical record review that two of the patients were inpatient deaths who died as an inpatient at the hospital. The other 09 patients who died outside the hospital only 4 could be verified. The HCFA data was correct as to dates of all deaths with the exception of the two above.

The diagnostic categories of mortality rates for Arab Hospital were all within the range of predicted mortality rates. After review of the records it was noted that category changes were made on five categories. The reason for the category changes were the principal diagnosis code was used as cause of death on 3 charts which was not the cause of death. The other two charts were coding errors which were not the causes of death.

The three categories which were at the upper end of range of predicted mortality rates; severe heart disease, severe acute heart disease and pulmonary disease were all reviewed and it was noted that all had acceptable comorbid conditions and or complications. It was also noted that comorbid conditions or complications not listed in HCFA model were also present. It was also noted after review that the average age of the 41 Medicare patients who died was 78 years of age. It was also found that occasionally a nursing home patient was sent here to die since a nursing home is in the rural community. It was also noted with no Hospice Hospital occasionally a terminally ill patient will be admitted with death expected.

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

ARAB HOSPITAL
ARAB, ALABAMA
35016

JESSE G. BROWN
ADMINISTRATOR

October 23, 1987

Hospital ID Provider # 010010

Patients listed as having died with incorrect dates.

Patient ID Number (HIC)	Age	Surname	Sex	Diagnostic Category	Adm Date	Disch Date	Death Date
[REDACTED]	69	[REDACTED]	M	ME	3/17/86	3/22/86	3/30/86
Corrected: "	"	"	"	CA	3/26/87	3/30/86	3/30/86
[REDACTED]	66	[REDACTED]	M	PN	11/14/86	11/15/86	11/16/86
Corrected:							
"	"	"	"	"	11/14/86	11/15/86	11/15/86

Diagnostic Category Changes and Reasons:

Patient ID Number (HIC)	Age/Sex	Surname	Reason
[REDACTED]	69/M	[REDACTED]	Changed from ME to CA admitted for dehydration; death from CA of lung.
[REDACTED]	76/M	[REDACTED]	Changed from PN to CA admitted for pneumonia with cause of death being CA of esophagus
[REDACTED]	86/F	[REDACTED]	Changed from UN to HM- Principal dx URI with cause of death being Aortic Valve Disease with cardiac decompensation.
[REDACTED]	74/F	[REDACTED]	Changed from UN to HS. Coding error- Coded 799.1. Should be coded 410.9 with 799.1 second code. Diagnosis Acute Pulmonary arrest secondary to M.I.
[REDACTED]	76/M	[REDACTED]	Changed from UN to PN. Diagnosis of Pneumonia Candida Albicans. Coded organism first rather than pneumonia.

ATTACHMENT 5

HOSPITAL PROVIDER # 010010
Hospital year Jan.-Dec. 1986

Worksheet 1: Analysis of Reporting Errors

Diagnostic Category	Deaths Reported by HCFA		Deaths Verified by Hospital*	
	In-hospital	Post-hospital	In-hospital	Post-hospital
CA -- Cancer		1	1	
CE -- Cerebrovascular Accidents	4		4	
GC -- Gastrointestinal Catastrophes	1	1	1	1
GI -- Gastrointestinal Disease	1		1	
GU -- Urologic Disease				
GY -- Gynecologic Disease				
HL -- Low Risk Heart Disease		2		1
HM -- Severe Chronic Heart Disease'	6	1	6	1
HS -- Severe Acute Heart Disease	5	1	5	
ME -- Metabolic/Electrolyte Disturbances	2	2	2	
OP -- Orthopedic Disorders				
PN -- Pulmonary Disease	8	3	9	1
RN -- Renal Disease				
SE -- Sepsis				
TR -- Severe Trauma				
OP -- Ophthalmologic Disease				
UN -- Other Diagnoses	3		3	
Total -- All Categories	30	11	32	4

NOTES: In the Deaths reported by HCFA, tabulate the number of deaths assigned to each diagnostic category on the individual care listing. In-hospital deaths are those patients whose date of discharge is the same as the date of death; post-hospital deaths are those patients whose date of death is after the date of discharge. Verified deaths should include those patients who are known to have died or whose status 30-days after discharge from the hospital cannot be determined. Verified deaths should also exclude patients that the hospital does not believe were ever admitted to the hospital.

October 23, 1987

AUTAUGA MEDICAL CENTER

124 South Memorial Drive, P.O. Box 460, Prattville, Alabama 36067 Telephone (205) 365-0651



FEDERAL EXPRESS

October 27, 1987

Mr. Harvey Brook
6300 Security Blvd.
Meadows East Bldg.
Room 2D2
Baltimore, MD 21207

Re: COMMENTS ON THE HCFA MORTALITY DATA
AUTAUGA MEDICAL CENTER
PRATTVILLE, ALABAMA 36067

Dear Mr. Brook:

While we support HCFA's interest and concern about the quality of hospital care, we feel that the HCFA mortality data are not, in themselves, measures of a hospital's performance or quality. The testing of any statistical model is key to ensuring accurate results and no evidence indicates that this model has been validated as an indicator of quality.

We also feel that the mortality data cannot be used as a predictor of a hospital's mortality rate. The model fails to consider a wide range of factors that have a significant impact on mortality which include the patient's general health status, the state of the patient's illness, the patient's psychological condition, family support and many other socioeconomic factors.

The data used by HCFA indicates that a total of 60 Medicare patients admitted to Autauga Medical Center died within 30 days of admission. Of these, 50 died while still a patient of the hospital, while 10 died after discharge. HCFA's data further indicates that there were 472 Medicare admissions which was the basis for the calculated mortality rates. Our own records indicate that 832 Medicare admissions occurred in 1986. Presumably the discrepancy reflects multiple admissions of individual beneficiaries to different hospitals and this could substantially alter the percentages as reflected in the study.

William L. Roper, M.D.
October 27, 1987
Page 2

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

In spite of predisposing factors and comorbid conditions, the hospital's actual mortality rate never falls out of the range of the predicted mortality rate in any of the diagnostic categories.

Yours truly,

Willis S. Sanders III

Willis S. Sanders, III
Chief Executive Officer

WSSIIE/jr

Baptist Medical Center
2105 East South Boulevard
P.O. Box 11010
Montgomery, Alabama 36198
Telephone: 205/288-2100

W. Taylor Morrow
President

William C. Bentley
Senior Vice President

October 26, 1987

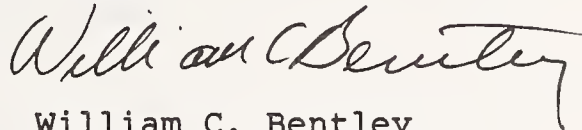
William L. Roper. M.D.
Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
Post Office Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Enclosed are our comments to be published with the HCFA
information release scheduled for December, 1987.

We appreciate the opportunity to respond.

Sincerely,



William C. Bentley
Senior Vice President

WCB:cgg

enclosure

A Baptist Health Service

Baptist Medical Center falls favorably within the mortality ranges listed in the HCFA statistical model. Ideally, an assessment of a hospital's performance should include consideration of several quality indicators with mortality data being but one of those factors. The data listed for Baptist Medical Center appears to be reasonably accurate although we were unable to determine the actual cause of death for patients who were discharged from the hospital, but listed as part of this study.

Baptist Medical Center has an extensive quality assurance program which covers all aspects of the professional services offered by physicians and hospital staff. We are always seeking ways to improve our services and welcome any objective evaluation of our hospital and its programs.



Baptist Medical Center Montclair

800 Montclair Road
Birmingham, Alabama 35213
Telephone 205/592-1000

October 26, 1987

Health Care Finance Administration
Health Standard Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Sir:

In light of our ongoing quality assurance program, we at Baptist Medical Center Montclair find no revelations in the HCFA report, and are gratified that our mortality rates for medicare patients fall well within the predicted range in all categories. We do find, in some instances, our numbers are at variance with HCFA's by as much as 16%. Additionally, total admissions differ by several hundred.

These discrepancies tend to discredit the reliability of the input to the data analysis program. We would further observe that absent the development and application of sophisticated and tested severity indices, credible comparisons among institutions can not be made.

Sincerely,

Dennis A. Hall, President

Lachlan L. Campbell, M.D.
Quality Assurance

DAH/sks



Baptist Medical Center Princeton

701 Princeton Avenue
Birmingham, Alabama 35211
Telephone 205/783-3805

Byron R. Harrell, F.A.C.H.E.
President

October 26, 1987

The Honorable William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Attn: HSQ-148-GNC
P.O. Box 26676
Baltimore, Maryland 21201

Dear Dr. Roper:

Baptist Medical Center Princeton has provided compassionate care in a Christian environment to the Birmingham community since 1922. Princeton is a 524 bed, non-profit, church related hospital providing care, education, research, and charity to the community.

The Princeton goal of delivering the highest quality of care possible is deeply rooted in it's mission. Princeton monitors patient care through Quality Assurance and Utilization Review programs established to assure the quality of it's services and the efficient use of resources. Princeton supports the provision of accurate data to the public in order for patients to make informed choices.

We are not persuaded that mortality data has been shown to be a valid predictor of a hospital's quality of care. Moreover, the ability to measure quality remains extremely limited. We are pleased that HCFA included a number of disclaimers as to the proper and efficient use of this data and believe that those who use this data can reach no definite conclusions. Accordingly, we do not understand the continued insistence by HCFA to release data which, by your own admission, is extremely limited. Members of the general public will inevitably make invalid comparisons.

Princeton supports the initiatives of such organizations as the Joint Commission on Accreditation of Health Care Organizations in establishing more precise hospital quality indices.

Data Verification/Analysis

Compared to many of the country's best hospitals (members of the Voluntary Hospitals of America, Inc.) Princeton patients are among the most critically ill in the country. However, Princeton falls within HCFA predicted mortality ranges in all except one category (Metabolic Electrolyte Disturbances).

In analyzing the data, a number of significant errors should be noted in the following table:

<u>Summary Analysis</u>	HCFA	% of	BMCP	% of
	Data	Total	Data*	Total
Total Medicare Admissions	4,098	100%	6,689**	100%

A Member of the Baptist Medical Centers System of Birmingham, Alabama

Expired in Hospital	378	9%	385	6%
Expired after Discharge	94	3%	78	1%
Total Expired W/in				
30 Days of Discharge	472***	12%	463	7%

* Source: Hospital and state Department of Health

** The discrepancies in Medicare admissions reflect multiple admissions to the hospital. HCFA's data did not include all of the patients' admissions -- only the patients' last.²

***The state Department of Health verified that nine of these patients have not expired; this is reflected in BMCP figure.

A review of the 16 diagnostic categories indicates that Princeton's actual mortality rate fell outside the range of the predicted mortality rate in only one category -- metabolic electrolyte disturbances.

<u>Metabolic Electrolyte Disturbances</u>	HCFA Data	BMCP Data
Expired in Hospital	23	24
Expired after Discharge	10	9
Total Expired W/in		
30 Days of Discharge	33	33

Conclusion

Individual, detailed review of the medical records of the patient's classified in the "Metabolic Electrolyte Disturbances" category shows a variety of contributing patient conditions were present. Some patients had multiple illnesses at the same time which increased the mortality rate but which were not recognized by HCFA.

The absence of a patient's family background and his ability to afford much earlier care, coupled with HCFA's failure to adjust the data for differences in the level of illness among Princeton patients, fatally flaws the data and the information. For instance, Princeton specializes in care for the terminally ill and this program should be accounted for in comparative hospital mortality figures. In the future, a refined model of data collection should be tested in a few hospitals in a representative sample across the country if fair and accurate comparisons are to be obtained.

Thank you for this opportunity to evaluate the data. Rest assured Princeton stands ready to work with HCFA on improving it's methods and information.

Respectfully,


Byron Harrell
President

BRH/vs

Attachment

ATTACHMENT 5

Worksheet 1: Analysis of Reporting Errors

Diagnostic Category	Deaths Reported by HCFA		Deaths Verified by Hospital*		DATA NOT VALID
	In-hospital	Post-hospital	In-hospital	Post-hospital	
CA -- Cancer	54	15	51	15	3
CE -- Cerebrovascular Accidents	34	3	35	2	
GC -- Gastrointestinal Catastrophes	14	3	13	4	
GI -- Gastrointestinal Disease	18	4	18	3	1
GU -- Urologic Disease	6	1	6	1	
GY -- Gynecologic Disease	0	0	0	0	
HL -- Low Risk Heart Disease	11	1	11	0	1
HM -- Severe Chronic Heart Disease	24	9	24	8	1
HS -- Severe Acute Heart Disease	36	0	36	0	
ME -- Metabolic/Electrolyte Disturbances	23	10	24	9	
OP -- Orthopedic Disorders	1	0	1	0	
PN -- Pulmonary Disease	58	25	63	19	1
RN -- Renal Disease	5	3	5	2	1
SE -- Sepsis	21	4	21	4	
TR -- Severe Trauma	13	0	13	0	
OP -- Ophthalmologic Disease	0	0	0	0	
UN -- Other Diagnoses	59	17	64	11	1
Total -- All Categories	378	94	385	78	9

NOTES: In the Deaths reported by HCFA, tabulate the number of deaths assigned to each diagnostic category on the individual care listing. In-hospital deaths are those patients whose date of discharge is the same as the date of death; post-hospital deaths are those patients whose date of death is after the date of discharge. Verified deaths should include those patients who are known to have died or whose status 30-days after discharge from the hospital cannot be determined. Verified deaths should also exclude patients that the hospital does not believe were ever admitted to the hospital.

NOTE: Data Not Valid (see attached incorrect data list)

BMC PRINCETON
HCFA MORTALITY DATA
INCORRECT DATA

HIC#	MR#	NAME	DC	AGE	SEX	DA	DD	DD	PDX	P	PROC	COMMENTS
[REDACTED]	[REDACTED]	[REDACTED]	CA	79	F	5/25/86	5/30/86	6/16/86	198.89			According to Public Health Dept. data, pt has not expired. Pt was registered as an outpatient at Princeton on 12/12/86.
[REDACTED]	[REDACTED]	[REDACTED]	CA	86	F	8/12/86	8/17/86	8/31/86	2030	4131		According to Public Health Dept. data, pt has not expired.
[REDACTED]	[REDACTED]	[REDACTED]	CA	77	F	11/6/86	11/14/86	11/14/86	1970	9215		According to Public Health Dept. data, pt has not expired. Pt discharged from Princeton 10/3/87.
[REDACTED]	[REDACTED]	[REDACTED]	CE	76	F	5/30/86	6/1/86	5/31/86	431	8651		Date of death is 6/1/86. Pt died in hospital.
[REDACTED]	[REDACTED]	[REDACTED]	GC	77	M	10/15/86	10/17/86	10/17/86	5780	8914		Correct adm date is 10/13/86.
[REDACTED]	[REDACTED]	[REDACTED]	GI	82	M	12/3/86	12/24/86	12/31/86	5781	9322		According to Public Health Dept. data, pt has not exp.
[REDACTED]	[REDACTED]	[REDACTED]	GI	84	F	2/1/86	2/15/86	2/28/86	5589	8954		Correct date of death is 2/17/86.
[REDACTED]	[REDACTED]	[REDACTED]	HL	79	M	6/24/86	7/17/86	7/22/86	4140	3614		According to Public Health Dept. data, pt has not expired.
[REDACTED]	[REDACTED]	[REDACTED]	HM	78	M	1/30/86	2/7/86	2/13/86	4280	8954		Correct date of death is 2/24/86.
[REDACTED]	[REDACTED]	[REDACTED]	HM	74	F	11/10/86	11/23/86	11/30/86	40291	8872		Correct date of death is 11/24/86.

BMC PRINCETON
HCFA MORTALITY DATA
INCORRECT DATA

HIC #	MR#	NAME	DC	AGE	SEX	DA	DD	PDX	P PROC	COMMENTS
[REDACTED]	[REDACTED]	[REDACTED]	HS	76	M	7/1/86	7/10/86	4271	9962	Correct date of death is 7/11/86. Correct discharge date is 7/11/86.
[REDACTED]	[REDACTED]	[REDACTED]	ME	70	F	1/20/86	1/20/86	2765	8622	Correct date of death is 1/20/86.
[REDACTED]	[REDACTED]	[REDACTED]	ME	60	M	1/6/86	1/6/86	2765	9960	Correct date of death is 1/7/86. Correct discharge date is 1/7/86.
[REDACTED]	[REDACTED]	[REDACTED]	ME	76	F	11/14/86	11/18/86	2765	8954	According to Public Health Dept. data, pt. has not expired. Pt discharged from from Princeton on 6/18/87.
[REDACTED]	[REDACTED]	[REDACTED]	PN	70	M	4/12/86	4/24/86	4821	9399	According to Public Health Dept. data, pt has not expired.
[REDACTED]	[REDACTED]	[REDACTED]	PN	83	M	8/22/86	8/27/86	9/19/86	486	Correct adm date is 9/13/86. Correct discharge date is 9/19/86. Pt did not expire outside hospital.
[REDACTED]	[REDACTED]	[REDACTED]	PN	67	M	1/26/86	1/30/86	1/31/86	4281	Correct date of death is 1/30/86.
[REDACTED]	[REDACTED]	[REDACTED]	PN	60	M	5/9/86	5/20/86	6/6/86	5119	3404 Correct date of death is 6/8/86.
[REDACTED]	[REDACTED]	[REDACTED]	PN	70	M	12/9/86	12/14/86	12/31/86	4823	8703 Correct date of adm is 11/27/86. Correct date of death is 12/14/86.

BMC PRINCETON
HCFA MORTALITY DATA
INCORRECT DATA

HIC #	MR#	NAME	DC	AGE	SEX	DA	DD	DD	PDX	P PROC	COMMENTS
[REDACTED]	[REDACTED]	[REDACTED]	PN	80	M	2/20/86	2/24/86	2/27/86	4824	8954	Correct date of death is 2/24/86.
[REDACTED]	[REDACTED]	[REDACTED]	PN	67	M	1/17/86	1/24/86	1/31/86	4822	8954	Correct date of death is 1/29/86.
[REDACTED]	[REDACTED]	[REDACTED]	PN	90	M	8/8/86	8/9/86	8/31/86	486	9960	Correct date of death is 8/9/86.
[REDACTED]	[REDACTED]	[REDACTED]	PN	79	M	1/4/86	1/6/86	1/7/86	496	9392	Correct date of death is 1/6/86.
[REDACTED]	[REDACTED]	[REDACTED]	PN	76	F	12/7/86	12/18/86	12/31/86	4821		Correct date of death is 12/21/86.
[REDACTED]	[REDACTED]	[REDACTED]	PN	74	F	4/22/86	4/27/86	4/29/86	5191	5794	Correct date of death is 4/27/86.
[REDACTED]	[REDACTED]	[REDACTED]	RN	72	F	5/5/86	5/12/86	5/5/86	585	5493	According to Public Health Dept. data, the pt has not expired. Pt registered at Princeton on 7/1/87 as an outpatient.
[REDACTED]	[REDACTED]	[REDACTED]	SE	74	M	1/19/86	1/27/86	1/30/86	0388	8954	Correct date of death is 1/27/86.
[REDACTED]	[REDACTED]	[REDACTED]	SE	74	F	3/2/86	3/3/86	3/3/86	0389	8954	Correct adm date is 3/27/86. Correct discharge date is 4/8/86. Correct date of death is 4/8/86.
[REDACTED]	[REDACTED]	[REDACTED]	TR	89	F	6/24/86	6/24/86	6/24/86	85221	9960	Correct disch date is 6/25/86. Correct date of death is 6/25/86.

BMC PRINCETON
HCFA MORTALITY DATA
INCORRECT DATA

HIC #	MR#	NAME	DC	AGE	SEX	DA	DD	DD	PDX	P	PROC	COMMENTS
[REDACTED]	[REDACTED]	[REDACTED]	UN	71	F	9/3/86	9/7/86	9/8/86	V581	9925		According to Public Health Dept. data, the pt has not expired.
[REDACTED]	[REDACTED]	[REDACTED]	UN	79	F	7/7/86	7/8/86	7/18/86	9351	9802		Correct date of death is 7/19/86.
[REDACTED]	[REDACTED]	[REDACTED]	UN	82	F	12/15/86	12/19/86	1/5/87	7803	8703		Correct date of adm is 12/25/86. Correct discharge date is 1/5/87.
[REDACTED]	[REDACTED]	[REDACTED]	UN	76	M	12/24/86	12/25/86	12/25/86	4423	540		Correct date of death is 12/24/86. Correct date discharge date is 12/24/86.
[REDACTED]	[REDACTED]	[REDACTED]	UN	59	M	1/20/86	2/6/86	2/7/86	V580	9229		Correct discharge date is 2/7/86.
[REDACTED]	[REDACTED]	[REDACTED]	UN	69	M	9/24/86	9/24/86	10/4/86	V581	9925		Correct adm date is 10/3/86. Correct discharge date is 10/4/86. Pt did not expire outside hospital.
[REDACTED]	[REDACTED]	[REDACTED]	UN	74	F	2/20/86	2/26/86	2/27/86	29040	9604		Correct date of death is 2/26/86.
[REDACTED]	[REDACTED]	[REDACTED]	UN	89	M	12/8/86	12/15/86	12/16/86	7870	9392		Correct date of death is 12/15/86.



BAPTIST MEMORIAL HOSPITAL

1007 Goodyear Avenue, Gadsden, Alabama 35999
Telephone: 205-543-4983

October 23, 1987

Robert J. Corey
Executive Director
Administrator

William L. Roper, M.D.
Administrator
Dept. Health & Human Services
Health Care Financing Administration
P. O. Box 26684
Baltimore, Maryland 21207

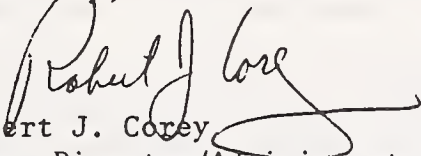
RE: Release of Mortality Information

Dear Dr. Roper:

Baptist Hospital of Gadsden, Inc., which operates under the name of Baptist Memorial Hospital, is a not-for-profit general acute care hospital in Gadsden, Alabama. Owned by the Etowah Baptist Association, the hospital has a licensed capacity of 346 beds. Our Medicare Provider Number is 01-0040.

Improvement in the quality of medical care delivered to all patients is a primary goal of our hospital. Objective measurement, analysis, and dissemination of information about quality is key to achieving that goal. The release of data on quality performance to the public can promote consumer awareness of quality differences and may assist their decision making. To that end, HCFA's publication of hospital mortality data has the potential of being a laudable effort. However, we would be quick to point out (as we are sure many others will), that HCFA should continue to refine the statistical formula to take into consideration other important variables that also impact mortality rates. To do this will make the data more meaningful for all. Baptist Memorial Hospital will always be willing and ready to assist HCFA in this endeavor.

Sincerely,


Robert J. Corey
Exec. Director/Administrator

RJC:11s



BESSEMER CARRAWAY MEDICAL CENTER

P.O. Box 847 • Highway 11 South • (205) 426-7000 • Bessemer, Alabama 35021-0847

October 26, 1987

HOSPITAL # 010114

Data Verification:

The data used by HCFA indicates that a total of 196 Medicare patients admitted to Bessemer Carraway Hospital died within 30 days of admission. 35 of these deaths were listed as out of hospital deaths. This data has been confirmed with the exception of out of hospital deaths which our records indicate 34. (Correction Attached)

Comments:

The Governing Board, Medical Staff and Administration of Bessemer Carraway Medical Center share the interest and concern of HCFA regarding quality of care for all patients.

The Medicare Mortality data should prove useful to all hospitals as a guide to further study to ensure quality of care. Since it is difficult to include in the Statistical Model factors which impact significantly on mortality rates, individual case review relates more directly to quality of care. Some of these aforementioned factors are 1) an individual's psychosocial status, 2) concomitant extenuating medical conditions, 3) socio-economic factors, 4) family support, 5) stage of illness, 6) response to disease and/or treatment.

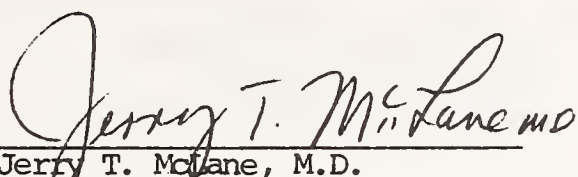
Even though this hospital did not exceed the range of predicted mortality in any category, we chose to conduct a second review (previously concurrently reviewed by committees) of records included in categories of the highest mortality range. This 2nd review revealed no quality of care problems in the treatment of these patients. The findings were as followed:

- 1.) Cancer - 92% of these patients were admitted to the hospital for treatment of acute episodes of complications of the malignancy. Death was a significant possibility at the time of admission or discharge due to end-stage disease process. These patients also came from a home setting with Home Health Care, Hospice Care, or Nursing Home. 23% died outside the hospital. Eight percent (8%) of these patients were found to have a cause of death unrelated to the cancer i.e.; other comorbid conditions. Average age of these patients was 73 years.

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

Hospital # 010114
October 26, 1987
Page II

- 2.) Sepsis - 100% of these patients admitted to the hospital with a significant possibility of death due to super-imposed infections on other multi-system disease processes, or comorbid conditions. Sixty one (61%) percent of these patients admitted directly from nursing homes. Average age of these patients was 78 years.


Jerry T. McLane, M.D.

Chairman/Quality Assurance Committee

Blount Memorial Hospital

1000 LINCOLN AVENUE
ONEONTA, ALABAMA 35121
205 - 625-3511

October 27, 1987

The Administrator
Department of Health and Human Services
c/o Health Care Financing Administration
Washington, DC 20201

Re Mortality Information
Blount Memorial Hospital
Oneonta, AL 35121
Medicare Provider #010050

Dear Sir:

While we support HCFA's interest and concern about the quality of hospital care, we feel that the HCFA mortality data are not, in themselves, measures of a hospital's performance or quality. The testing of any statistical model is key to ensuring accurate results and no evidence indicates that this model has been validated as an indicator of quality. We also feel that the mortality data cannot be used as a predictor of a hospital's mortality rate. The model fails to consider a wide range of factors that have a significant impact on mortality which include the patient's general health status, the stage of patient's illness, the patient's psychological condition, family support and many other socio-economic factors.

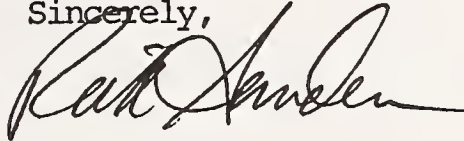
The data used by HCFA indicates that a total of 62 Medicare patients admitted to Blount Memorial Hospital died within 30 days of admission. Of these, 48 died while still a patient of the hospital, while 14 died after discharge. Our own records indicate that 1331 Medicare admissions occurred in 1986. Presumably the discrepancy reflects multiple admission of individual beneficiaries to different hospitals. We have no way of verifying whether the number of Medicare patients treated at Blount Memorial is correct. Our own records also indicate that of the 62 Medicare patients who died within 30 days of admission while still an inpatient, 1269 were still alive at the time of discharge. It is impossible to determine the percentage of the 14 patients dying after discharge who were in fact alive, as information concerning death after discharge is not included in the patient's medical record. Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

In one of the diagnostic categories, the hospital's actual mortality rates falls outside of the range of the predicted mortality rate.

Our hospital's higher than average mortality rate for cancer can be attributed to Blount County being a rural area and Blount Memorial Hospital having a higher than average number of patients 65 years and older. Of these 11 patients whose diagnostic category is listed as cancer, only 3 of these did not have an unusually large number of complicating or comorbid conditions. During the past ten months our hospital community relations department in conjunction with the American Cancer Society has reached over 2500 adult Blount County residents with educational material, programs and audio visual information regarding the causes and prevention of many types of cancer.

If further information is needed, please do not hesitate to contact us.

Sincerely,

A handwritten signature in black ink, appearing to read "Rick Sanders", written over a horizontal line.

Rick Sanders
Administrative Assisant

RS/mht



Boaz-Albertville Medical Center

(205) 593-8310 • POST OFFICE DRAWER Z • BOAZ, ALABAMA 35957-0999

MARLIN HANSON, ADMINISTRATOR

COMMENTS ON THE HCFA MORTALITY DATA

While we support HCFA's interest and concern about the quality of hospital care, we feel that the HCFA mortality data are not, in themselves, measures of a hospital's performance or quality. The testing of any statistical model is the key to ensuring accurate results and no evidence indicates that this model has been validated as an indicator of quality.

We also feel that the mortality data cannot be used as a predictor of a hospital's mortality rate. The model fails to consider a wide range of factors that have a significant impact on mortality which include the patient's general health status, the stage of the patient's illness, the patient's psychological condition, family support and many other socio-economic factors.

This mortality data includes patients dying within thirty days following discharge. It is impossible for the Medical Center to determine the percentage of those patients dying after discharge as information concerning death following discharge is not included in the patient's medical record. The Medical Center also has no control over the quality or type of care the patient receives following discharge.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality data, it is impossible to verify the accuracy of the diagnostic or other data used in the analysis.

In one of the diagnostic categories, the Medical Center's actual mortality rate falls outside of the range of the predicted mortality rate. Our Medical Center's higher than average mortality rate for Pulmonary Disease can be attributed to being a referral center for four area nursing homes with 57% of the patients being referred to the Medical Center from these nursing homes. This factor is reflected in the average age of the patient being 79 with high concentrations of admissions in the age range of 81 to 90 years of age along with complicating disease processes resulting in these patients being classified as high-risk patients.

Mortality review has long been a part of the patient care evaluation process carried out by the Quality Assurance Program of the Medical Staff within the Medical Center. The program monitors the quality and appropriateness of care delivered to all patients with special emphasis on mortality case review.

Medicare Provider Number 01-0005

BRYAN W. WHITFIELD MEMORIAL HOSPITAL
DEMOPOLIS, ALABAMA 36732

PHONE (205) 289-4000
P. O. BOX 890

CHARLES E. NABORS
ADMINISTRATOR



October 26, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Re: Bryan W. Whitfield Memorial Hospital Comments
(Hospital Number 010112) on Mortality Data Submitted

Dear Sir:

Included hereto are the specific comments as related to the following
identified patients (HIC):

<u>Patient ID Number</u>	<u>Surname</u>	<u>Diagnostic Category</u>	<u>Comments</u>
[REDACTED]	[REDACTED]	CA	End Stage Treatment of Disease
[REDACTED]	[REDACTED]	CA	End Stage Treatment of Disease
[REDACTED]	[REDACTED]	CA	End Stage Treatment of Disease
[REDACTED]	[REDACTED]	CA	End Stage Treatment of Disease
[REDACTED]	[REDACTED]	CA	End Stage Treatment of Disease
[REDACTED]	[REDACTED]	CA	End Stage Treatment of Disease
[REDACTED]	[REDACTED]	CA	End Stage Treatment of Disease
[REDACTED]	[REDACTED]	CA	End Stage Treatment of Disease
[REDACTED]	[REDACTED]	CA	End State Treatment of Disease
[REDACTED]	[REDACTED]	CA	End Stage Treatment of Disease
[REDACTED]	[REDACTED]	CA	End Stage Treatment of Disease

Your consideration of the aforementioned is muchly appreciated.

With best regards,

Sincerely,

Charles E. Nabors
Administrator

CEN:pah

Enclosure:

MEMBER
ALABAMA HOSPITAL ASSOCIATION
AMERICAN HOSPITAL ASSOCIATION

ACCREDITED BY
JOINT COMMISSION ON ACCREDITATION
OF HOSPITALS

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.



CARRAWAY METHODIST MEDICAL CENTER

1600 26th Street North Birmingham, Alabama 35234 Telephone 226-6000

CMMC

Hospital Provider #01-0064

COMMENTS ON THE HCFA MORTALITY DATA

DATA VERIFICATION:

The data used by HCFA indicates that a total of 381 Medicare patients admitted to CMMC died within 30 days of admission. Of these 327 died while still a patient of the hospital, while 53 died after discharge.

Our own records indicate that a total of 380 Medicare patients admitted to CMMC died within 30 days of admission. This discrepancy is due to HCFA identifying one patient in the GU category as a CMMC patient, while our records do not reflect ever treating this patient. (Correction attached).

In none of the diagnostic categories included in the Medicare Mortality data did this hospital exceed or fall outside the range of the predicted mortality rates.

COMMENTS:

HCFA's interest and concern about the quality of care of the Medicare patient is shared by the hospital's Governing Board, Administration and Medical Staff. We recognize the usefulness of the data as a guide to selective areas for review in order to ensure quality of care.

Many factors such as an individual's psychological as well as physical

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

health status, socio-economic conditions, family support, stage of illness, and response to disease and/or treatment have a significant impact on mortality rates. We recognize the difficulty of the inclusion of these factors in the statistical model. Mortality cases are reviewed concurrently at this hospital by peer groups and processed through the quality assurance committee with reports to the Executive Committee of the Medical Staff. However, a process of a second peer review based on the HCFA data was conducted. Although we did not exceed the range of predicted mortality in any category our highest range was in Urological disease. Review findings in this category were as follows:

1. Average age of these patients was 89 years.
2. 80% admitted to the hospital directly from a nursing home.
3. All admitted with a diagnosis of Urinary Tract Infection
superimposed on multi-system end stage disease processes.


James D. Hallmark
Administrator

CENTRAL ALABAMA COMMUNITY HOSPITAL

COMMENTS ON THE HCFA MORTALITY DATA

Central Alabama Community Hospital

Clanton, Alabama

INTRODUCTORY COMMENTS

While we support HCFA's interest and concern about the quality of hospital care, we feel that the HCFA mortality data are not, in themselves, measures of a hospital's performance or quality. The testing of any statistical model is key to ensuring accurate results and no evidence indicates that this model has been validated as an indicator of quality.

We also feel that the mortality data cannot be used as a predictor of a hospital's mortality rate. The model fails to consider a wide range of factors that have a significant impact on mortality which include the patient's general health status, the stage of patient's illness, the patient's psychological condition, family support and many other socioeconomic factors. The data also fails to consider the type services offered by individual hospitals in determining mortality statistics.

DATA VERIFICATION

The data used by HCFA indicates that a total of 61 Medicare patients admitted to Central Alabama Community Hospital died within 30 days of admission. Of these, 47 died while still a patient of the hospital, while 14 died after discharge. Our records indicate that one of the 61 deaths included in HCFA's mortality data did not occur in our facility. The patient was transferred to another acute care facility and presumably died there.

HCFA reports 361 individual Medicare beneficiaries were treated at our hospital in 1986, however, verification of this figure is unavailable at this time. Our own records indicate 603 Medicare admissions in 1986. The discrepancy in these figures reflects multiple admissions of the same beneficiaries. It is impossible to determine the cause of death of the 14 patients who died after discharge as this information is not included in the medical record. It is possible that some of these deaths resulted from accidents or other unrelated conditions, as the statistics were based on diagnosis at discharge and not on actual cause of death. It is this hospital's policy not to contact family members of patients who die after discharge as it is felt that the family's grief is personal and private.

"A HealthCorp FACILITY"

1010 LAY DAM ROAD • CLANTON, ALABAMA 35045 • (205) 755-2500

It is notable, however, that every mortality in this hospital is screened for nationally-accepted appropriateness criteria first by the hospital's Quality Assurance Committee and then by its Medical Staff. Appropriate action is taken to address any problem noted by this review.

Every effort is made in a systematic manner to assure that all patients in our facility receive quality care as determined appropriate by today's accepted medical practice standard of care.

INTERPRETIVE REMARKS

In only one of the diagnostic categories, does the hospital's actual mortality rate fall outside of the range of the predicted mortality rate. We feel that this portrays the high quality of care given at our facility. This is especially evident when considering that the overall average age of all Medicare deaths was 80, and the average age of the CVA deaths category was 85.

UNIQUE SERVICES RESULTING IN HIGHER THAN AVERAGE MORTALITY

Our hospital's mortality rate for any category of Medicare beneficiaries can easily be affected by the type service we offer. In 1986, the only specialties offered were family practice, general surgery, and internal medical. Two of these services concentrate on non-acute, more chronic cases. This shifts our caseload to the type client who has been treated by sub-specialists elsewhere and sent back to their referring physician for palliative care when optimum rehabilitation has been achieved. This type "coming home to die" phenomenon will shift mortality data unfavorably for community hospitals whose admission census is often predominantly elderly. In 1986, 40% of all our admissions were Medicare.

RESULTS OF PRELIMINARY MEDICARE RECORD REVIEW

All of the 12 deaths in the cerebrovascular accident category were again screened for this analysis. All but two had at least one comorbid condition and half of them had multiple comorbid conditions. All of these twelve had complicating chronic factors that were not considered by HCFA in preparing their analysis data. We feel that this significantly alters the statistical computation that raises our "actual mortality rate" above the range of "predicted mortality rate" for this category.

As mentioned in the previous section, considering other factors not addressed in HCFA's analysis data we feel that our overall "actual mortality rate" due to all causes was unfavorably altered.

We do, however, appreciate the opportunity to offer our high quality of care to all of our community-elderly or young-and will continue to strive to improve this level of care so as to remain accredited by nationally-accepted criteria in all phases of quality assurance review.



Chambers
County
Hospital

Gil McKenzie
Administrator

COMMENTS ON THE HCFA MORTALITY DATA

Chambers County Hospital

INTRODUCTORY COMMENTS

While we support HCFA's interest and concern about the quality of hospital care, we feel that the HCFA mortality data are not, in themselves, measures of a hospital's performance or quality. The testing of any statistical model is key to ensuring accurate results and no evidence indicates that this model has been validated as an indicator of quality.

We also feel that the mortality data cannot be used as a predictor of a hospital's mortality rate. The model fails to consider a wide range of factors that have a significant impact on mortality which include the patient's general health status, the stage of patient's illness, the patient's psychological condition, family support and many other socioeconomic factors.

In our quest to ensure quality patient care at our facility we review each death on an individual basis. All deaths are reviewed by a physician that had no responsibility for the management of the patient's condition while he or she was a patient in our hospital. We feel that this method of individual objective quality assurance will expose any questions concerning our hospital's mortality rate prior to any statistical trends actually being established.

INTERPRETIVE REMARKS

In two of the diagnostic categories, the hospital's actual mortality rate falls outside of the range of the predicted mortality rate. In the diagnostic category of cancer (CA) 100% of our total deaths (or four patients) had been diagnosed previously as terminal and death was the expected outcome upon admission. In the diagnostic category of severe acute heart disease (HS) there were five deaths. Of these five deaths two of them were in the hospital for only one day and did not survive the severe cardiac arrest that initially prompted their emergency room visit at our hospital. Of the three remaining deaths in this category two of them had request by the patient or family that no aggressive measures be taken to sustain the patient's life.

Citizens Hospital

TALLADEGA, ALABAMA 35160 — 205/362-8111



November 2, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

RE: Mortality Rate Data

Dear Sir:

This letter is in response to the Mortality Rate Data sent to Citizens Hospital by the Health Care Financing Administration. Our records indicate some discrepancies with the statistical report generated by your office. They are as follows:

CANCER: Citizens Hospital had fifteen patients die with cancer. Twelve of these patients died in the hospital and three patients with cancer died at home. Your records indicated that we had eighteen deaths. Our records indicated we had fifteen.

CVAs: Our records indicate that we had seven patients with this diagnosis to die in the hospital. Two patients were at home, three were in nursing homes and two died in other hospitals. Your records indicated that we had fourteen deaths with this diagnosis. This is an error of seven patients.

GASTROINTESTINAL CATASTROPHIES: Our records indicate that we had twenty patients to die in the hospital and two patients died at home.

GASTROINTESTINAL DISEASE: Our records indicated that we had three deaths with this diagnosis. Two of these died at home and one in another hospital. None died at our hospital.

UROLOGY: Our records indicate that we had three deaths with this diagnosis. Two of these patients died in nursing homes and one died at home. None in the hospital.

LOW RISK HEART DISEASE: Our records indicate that we had two patients die with this diagnosis. Two patients died in the hospital and one at home and one in a nursing home.

CHRONIC HEART DISEASE: Our records indicate that we had six patients die with this diagnosis. Five patients died in the hospital and one died at a nursing home.

Health Care Financing Administration
November 2, 1987
Page 2

SEVERE HEART DISEASE: Our records indicate that we had nine patients die with this diagnosis. Eight died in the hospital and one died at home.

PULMONARY DISEASE: Our records indicate that we had seven patients die with this diagnosis. Our records indicate that six of these patients died at home and one died in a nursing home.

SEVERE TRAUMA: Our records indicate that we had no one die with severe trauma in our hospital. One patient who was admitted to our hospital and discharged, died in a nursing home.

As you can see, there are errors in your report. Please make the corrections and forward a corrected copy to Citizens Hospital.

Thank you.


Jack B. Hethcox, FACHE
Administrator

JBH/gf



COMMUNITY HOSPITAL

FRIENDSHIP ROAD
TALLASSEE, ALABAMA 36078
283-6541

October 22, 1987

Medicare Provider No. 010034

COMMENTS:

After reviewing information received from the Health Care Financing Administration (HCFA) regarding mortality statistics, initial findings indicate that all percentages of deaths "assigned" to our facility fall within the range of predicted mortality rates.

Internal monitoring programs currently in place insure that all deaths occurring at the hospital are reviewed for quality and appropriateness of care.

While the validity of the methodology used in the HCFA study has not been verified by the health care industry and complete patient data has not been provided for our review, analysis of the available data provides the following additional information regarding deaths "assigned" to Community Hospital.

(Based on review of specific data for the 92 deaths "assigned to this facility)

-The average age for patients who expired is 80 years.

-The 74 inpatient deaths included 48 or 65% of cases in which the patient/family requested no resuscitative or life-prolonging measures be attempted. The remaining 24 or 35% of cases represented 24 high risk category patients with an average age of 78 years.

-High risk category patients comprised 74 or 80% of all deaths. Low risk category patients totalled 8 or 9% of deaths with all patients having co-existing high risk secondary diagnoses or complications not taken into consideration by this study (Example: prior heart attack or stroke). One exception noted in this area involved a death after discharge from unnatural causes. Cases not classified to either risk category represented a patient population with an average age of 76 years and co-existing high risk diagnoses or complications.

The patient population depicted by this preliminary analysis appears to correlate with our own internal mortality data for Medicare beneficiaries. Further verification of any similarities or discrepancies can only be accomplished when the complete data base is made available.

While Community Hospital's preliminary results appear favorable, we agree with the Health Care Financing Administration's recommendation that mortality information alone should not be used to make judgments about the quality of care in an individual hospital or to make comparisons among hospitals. We feel our ongoing mechanisms for monitoring care provide a more indepth and comprehensive review of the quality and appropriateness of care provided our patients.

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

Doctors Hospital of Mobile

P.O. Box 1708
1700 Center Street
Mobile, Alabama 36633

October 26, 1987

Department of Health and Human Service
Health Care Financing Administration
Mortality Data
Washington, D.C. 20201

RE: DOCTORS HOSPITAL
MEDICARE PROVIDER #010119

To Health Care Financing Administration
Comments on the HCFA Mortality Data

We have received and reviewed the selected Mortality Data due for publication in December 1987. In reviewing our own data we find with a few exceptions it to be basically correct (see attachment for areas of disagreement) All DRG catagories were in acceptable range.

██████████ admitted 08/23/86 to Psychiatry
transferred 08/24/86 to medical acute care,
expired 08/28/86 COPD, CHF

██████████ Metastatic CA,
fell at home, had open reduction,
send to Villa Mercy Hospice Unit, expired there

██████████ expired of CA in hospital not after
discharge

It is very difficult to determine number of deaths after discharge. Some were obvious because of terminal or chronic disease.

We would like to address some **Generic Observations:**

- This data does not take into consideration patients with terminal diseases not appropriate for continued hospital stay. Discharge DRG reflects illness which caused admission not terminal disease. Example: patient coded ME yet had terminal CA. Death in this instance could be misleading and indicate premature discharge.

- Patients death within thirty days of discharge may be due to unrelated problems such as a motor vehicle accident or other acute trauma.
- Prior to June, 1984, inflated numbers of acute care admissions caused mortality figures to be somewhat diluted as compared to mortality rates under the PPS guidelines. Now with intensive admission review criteria and resultanty decreased numbers of appropriate acute care admissions, mortality rates appear higher.
- Predictably all births will result in deaths after some period of time since death is an outcome of life. Mortality figures that fail to identify severity of illness at time of the last admission in an acute care setting simultaneously fail to accurately describe anything but a predictable happenstance.
- Lastly but of great importance is the legal fishbowl in which hospitals have to operate. Lawsuits have fostered the expectation that all illness will have a good outcome. By using mortality as a measure of care HCFA may appear to endorse this belief.

While understanding HCFA's concern regarding quality of care, we would encourage you to continue to develop a model which can more accurately measure quality performance in a hospital. In our opinion, mortality rates are not adequate tools to judge quality of care.

Thank you for giving us the opportunity to review this data prior to publication.

Sincerely,



Steve Loescher
Administrator

SL:mh

Worksheet 1: Analysis of Reporting Errors

010119

Dorland Hospital

Diagnostic Category	Deaths Reported by HCFA		Deaths Verified by Hospital	
	In-hospital	Post-hospital	In-hospital	Post-hospital
CA -- Cancer	8	3	8	3
CE -- Cerebrovascular Accidents	3	1	3	1
GC -- Gastrointestinal Catastrophes	2		2	
GI -- Gastrointestinal Disease	1		1	
GU -- Urologic Disease	2		2	
GY -- Gynecologic Disease	1		1	
HL -- Low Risk Heart Disease	1	1	1	1
HM -- Severe Chronic Heart Disease	6	1	6	1
HS -- Severe Acute Heart Disease	3		3	
ME -- Metabolic/Electrolyte Disturbances	3	1	3	1
OP -- Orthopedic Disorders	1		1	
PN -- Pulmonary Disease	10	1	11	2
RN -- Renal Disease	1		1	
SE -- Sepsis	2	1	2	1
TR -- Severe Trauma	2	1	2	1
OP -- Ophthalmologic Disease	2		2	
UN -- Other Diagnoses	7	4	9	2
Total -- All Categories	48	14	51	11

NOTES: In the Deaths reported by HCFA, tabulate the number of deaths assigned to each diagnostic category on the individual care listing. In-hospital deaths are those patients whose date of discharge is the same as the date of death; post-hospital deaths are those patients whose date of death is after the date of discharge. Verified deaths should include those patients who are known to have died or whose status 30-days after discharge from the hospital cannot be determined. Verified deaths should also exclude patients that the hospital does not believe were ever admitted to the hospital.



October 19, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Re: HCFA Mortality Rates for
East Alabama Medical Center
Provider #010029

Dear Dr. Roper:

I wish to make the following comments on the HCFA mortality data. The interest and concern HCFA has shown in the quality of hospital care is admirable; however, the use of an unvalidated statistical model, which includes patients who die outside the hospital but excludes patients who die within the hospital if longer than 30 days after admission, certainly must give rise to serious doubts about the data as an accurate predictor of a hospital's mortality rates.

The data used by HCFA indicates that a total of 185 Medicare patients admitted to East Alabama Medical Center died within 30 days of admission. Of these, 153 died while still a patient of the hospital, while 32 died after discharge. Our own records indicate 3395 Medicare admissions occurred in 1986, while HCFA data shows only 2079. Presumably the discrepancy reflects multiple admissions of individual beneficiaries.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

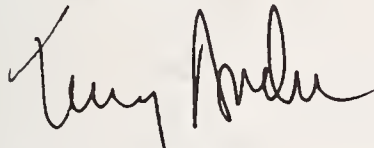
In all sixteen diagnostic categories, East Alabama Medical Center's actual mortality rate falls within the predicted mortality rate. We feel this is a very positive reflection on our staff and physicians, especially in view of the fact that East Alabama Medical Center is a regional referral center which often receives more acutely ill patients.

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

We have identified several errors in the dates reported by HCFA.
Please note these corrections on the attached pages.

Our staff and administration is proud of the quality of care
provided at East Alabama Medical Center. We urge HCFA to
reconsider the inadequacies of the present statistical model and
to continue efforts to develop a model that will more accurately
reflect that quality of care.

Sincerely,



Terry Andrus
Administrator

TA/ld

Attachment



ELMORE COUNTY HOSPITAL

P.O. BOX 120

WETUMPKA, ALABAMA 36092

PHONE (205) 567-4311

1201 COMPANY STREET

October 22, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
c/o Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

RE: Medicare #010097
Hospital Mortality Information

We have reviewed the information furnished by your department concerning the mortality information specific to Elmore County Hospital. We would like to request a correction in our information. There are two patients listed who were transferred from our hospital to acute care facilities for more intense treatment. These two patients are:

- (1) Patient ID #(HIC): [REDACTED]; Hospital [REDACTED], admitted 9/19/86; transferred to Baptist Medical Center, Montgomery, Alabama
- (2) Patient ID #(HIC): [REDACTED]; Hospital [REDACTED], admitted 8/27/86; transferred to St. Margaret's Hospital, Montgomery, Alabama

Below you will find the comments that we wish to have published with our statistics:

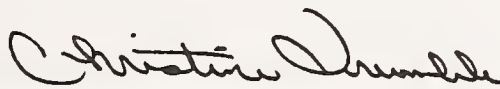
"We have reviewed the information supplied by the Department of Health Care Financing Administration (HCFA) about our hospital. We have requested that two patients who were transferred to other hospitals be deleted from our record.

We paid particular attention to the low risk and "other diagnosis" categories listed in the data from HCFA. At least one-half of these patients were in such a poor state of health that they had been classified as "Do Not Resuscitate". Some patients' "normal" state of health was very bad prior to hospitalization due to chronic or underlying conditions such as congestive heart failure or liver disease. We could find no unexpected deaths in these categories.

It should be noted that no person is "average". Each person is a unique human being and as a part of our ongoing quality assurance program each death is carefully reviewed through the process of peer review. Mortality data can be used as part of the review process; but, mortality rates alone cannot measure quality of care.

Through the review of all work at Elmore County Hospital, our medical staff, governing board, and employees are trying to ensure the highest quality of care possible for all patients. When problems are identified through any of the many mechanisms of review or indicators of quality care, corrective action is taken."

Sincerely,

A handwritten signature in cursive script, appearing to read "Christine Trumble".

Christine Trumble
Administrator

CT/jb

Fayette County Hospital

And Nursing Home

P.O. Drawer 878/1653 Temple Avenue N./Fayette, Alabama 35555/(205) 932-5966 MEDICARE PROVIDER
NUMBER: 0045

COMMENTS ON THE HCFA MORTALITY DATA

While we support HCFA's interest and concern about the quality of hospital care, we feel that the HCFA mortality data are not, in themselves, measures of a hospital's performance or quality. The testing of any statistical model is key to ensuring accurate results and no evidence indicates that this model has been validated as an indicator of quality.

We also feel that the mortality data cannot be used as a predictor of a hospital's mortality rate. The model fails to consider a wide range of factors that have a significant impact on mortality which include the patient's general health status, the stage of patient's illness, the patient's psychological condition, family support and many other socio-economic factors.

The data used by HCFA indicates that a total of 44 Medicare patients admitted to Fayette County Hospital died within 30 days of admission. Of these, 30 died while still a patient of the hospital, while 14 died after discharge. Our own records indicate that 721 Medicare admissions occurred in 1986. Of the 44 Medicare patients admitted to this hospital that died within 30 days of admission, 7 were under 65 years of age indicating that they had disabling medical problems or they would not have been eligible for medicare; 16 were 80 years or older with the average age being 73.3 years of age.

It is impossible to determine the percentage of the 14 patients dying after discharge who were in fact alive, as information concerning death after discharge is not included in the patient's medical record. Our records do indicate that 12 of the 14 discharged patient's were transferred to other health care facilities while only 2 were discharged to home.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

In all of the diagnostic categories, the hospital's actual mortality rate falls within the range of the predicted mortality rate. Even so, we still feel that the HCFA mortality data are not, in themselves, measures of a hospital's performance or quality.

George H. Lanier Memorial Hospital and Nursing Home

October 26, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Department of Health & Human Services
330 C Street, S.W.
Washington, D.C. 20201

COMMENTS ON THE HCFA MORTALITY DATA, LANIER MEMORIAL HOSPITAL, VALLEY, ALABAMA

In September, we were in receipt of data from Health Care Financing Administration that our mortality rate in the category of severe, acute heart disease was 62% and therefore greater than the range of predicted mortality rate as furnished by your department. You cited 21 deaths that occurred and were classified in that category. The 21 cases have been reviewed and upon review of the charts and the discharge data, we feel that six (6) of those cases should not have been included in that category. They should have been reclassified in other categories other than severe, acute heart disease. The cases specifically reviewed are the following:

1. Pt. [REDACTED]
Surname: [REDACTED] This patient had an apparent cardiac arrest at home and was resuscitated outside the hospital. Review of the record reveals description of cerebrovascular accident and cause of death was probably due to the cerebrovascular accident. The reason for admission, however, was the cardiac arrest that occurred at home. This would more accurately be classified under the category of cerebrovascular accident.
2. Pt. [REDACTED]
Surname: [REDACTED] Acute heart disease was not listed on the discharge sheet of this patient. He died of complications following the repair of a ruptured abdominal aortic aneurysm. His death was due to multiple complicating factors, including renal failure.
3. Pt. # not available
Surname: [REDACTED] This patient was included in your list of 21 patients even though it did not appear on our hospital I.D. number sheet. Patient died of a cardiopulmonary arrest as a terminal event of metastatic cancer of the colon. Cause of death

4800 48TH STREET
VALLEY, AL 36854
205/756-3111



"We Care"

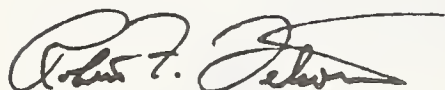
was, in fact, metastatic cancer of the colon, and she would be more properly classified in the category of cancer.

4. Pt. I.D. [REDACTED]
Surname: [REDACTED] This patient was not listed in your hospital patient identification printout, but was included in your number of 21. Patient died of a cardio-pulmonary arrest as a terminal event resulting from widespread lymphoma. This patient would have been more accurately categorized as dying of cancer.
5. Pt. I.D. [REDACTED]
Surname: [REDACTED] This patient was not included in your list of 13 on the hospital patient identification list, but was included in your survey of 21 deaths. This patient had cardiopulmonary arrest during induction of anesthesia for an elective gynecologic surgical procedure. Autopsy was done and showed no evidence of heart disease, and in fact, the coronary arteries were described as normal. She would more accurately be recategorized under the category of either gynecologic disease or low risk heart disease.
6. Pt. I.D. [REDACTED]
Surname: [REDACTED] This patient was not included in your list of 13 on your patient identification list, but was included in your total number of 21 patients who died. The autopsy that was performed on this patient showed evidence of chronic heart disease due to previous myocardial infarcts, and in fact, the patient did have an aneurysmal dilatation of the left ventricle. He would more accurately be categorized under severe chronic heart disease.

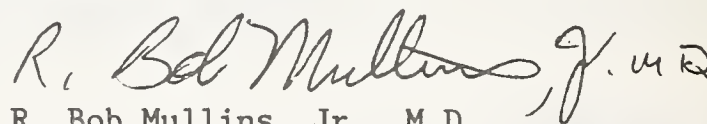
By removing these six (6) cases from the category of severe, acute heart disease and placing them in their appropriate categories, our number of deaths drops from 21 to 15, and this would certainly put us into the range of predicted mortality rates.

We trust that you will reconsider this information prior to releasing your data.

Sincerely yours,



Robert F. Letson
Administrator



R. Bob Mullins, Jr., M.D.
Chairman, Medical Records Committee

RBMjr/ap



JESSE G. BROWN
ADMINISTRATOR

State of the Art in
OLD FASHION CARE

VHA®

COMMENTS ON THE HCFA MORTALITY DATA
Guntersville Hospital, Guntersville, Alabama

Data Verification

The data used by HCFA indicates that 513 Medicare admissions occurred during 1986 while our own records reveal that 873 Medicare patients were admitted. This discrepancy is assumed to depict multiple admissions of individual patients. Fifteen (15) patients were reported by HCFA to have died within thirty days following discharge from this hospital; however, one (1) of these patients actually died while an inpatient here and one (1) died in another hospital. It was impossible to determine the percentage of the patients reported to have died within thirty days of discharge that may still be alive, as this information is not included in the patient's medical record. We did verify, however, that at least two (2) of these patients did not die on the dates presented in the HCFA data.

Interpretive Remarks

The hospital's overall mortality rate and the rates for the individual categories fell within the range of predicted mortality produced by HCFA. However, all categories with a death rate greater than the mean value of the predicted rate were investigated, and review of the records indicated the following findings:

Death was an expected consequence at the time of admission to the hospital in thirty-two (32) of the sixty-seven (67) cases reported. In other words, 48% of these patients were expected to die at the time of their admission to the hospital.

Twenty-eight (28) of the sixty-seven (67) had complications or comorbid conditions other than those included in the HCFA study.

Five (5) of the sixty-seven (67) had causes of death unrelated to the category to which they were assigned. This was of particular significance in one death assigned, in the HCFA data, to a low-risk category.

Two (2) of the seven (7) deaths assigned to the cancer category occurred within twenty-four (24) hours of

Guntersville Hospital

JESSE G. BROWN
ADMINISTRATOR

State of the Art in OLD FASHION CARE

admission to the hospital. Both these patients were admitted because of the family's inability to cope with the dying process at home, attributed in part to the lack of an organized Hospice program in this area.

The average age of death was 78 years.

Hospital = 010028
October 21, 1987

ANALYSIS OF REPORTING ERRORS
Guntersville Hospital
Guntersville, Alabama

Hospital #010028

Diagnostic Category	Deaths Reported by HCFA		Deaths Verified by Hospital	
	In-Hospital	Post-Hospital	In-Hospital	Post-Hospital
CA -- Cancer	7	2	7	2
CE -- Cerebrovascular Accidents	7	4	7	3*
GC -- Gastrointestinal Catastrophes	3	0	3	0
GI -- Gastrointestinal Disease	3	1	3	1
GU -- Urologic Disease	2	1	2	1
GY -- Gynecologic Disease	0	0	0	0
HL -- Low Risk Heart Disease	2	0	2	0
HM -- Severe Chronic Heart Disease	10	2	10	2
HS -- Severe Acute Heart Disease	6	0	6	0
ME -- Metabolic/Electrolyte Disturbances	0	1	1	0
OP -- Orthopedic Disorders	0	0	0	0
PN -- Pulmonary Disease	6	1	6	1
RN -- Renal Disease	0	0	0	0
SE -- Sepsis	3	0	3	0
TR -- Severe Trauma	0	0	0	0
OP -- Ophthalmologic Disease	0	0	0	0
UN -- Other Diagnoses	4	3	4	3
TOTAL -- All Categories	53	15	54	13

* Patient transferred to another acute care facility on 12-31-86, and death of 1-7-87 should have been attributed to the receiving hospital

STATISTICAL ERRORS - Case Listing

Patient ID #	Surname	Diagnostic Category	Age	Sex	Date of Admission	Date of Death	Corrected Date of Death
		CA	073	M	02/01/86	02/06/86	02/15/86
		ME	065	M	07/19/86	07/31/86	07/26/86

HARTSELLE MEDICAL CENTER

A National Healthcare, Inc. Facility

P. O. BOX 969
300 WEST PINE STREET
HARTSELLE, ALABAMA 35640
205/773-6511



October 20, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Sirs,

We are in receipt of the mortality statistics distributed
September 21, 1987.

These statistics have been verified and are correct.
It is noted that this facility is in the range of predicted
mortality rates for all diagnostic categories.

We do not agree that mortality data as such is an indicator
of quality of care at any facility.

Thank you for your opportunity to respond.

Sincerely,

Dale R. Mulder
Administrator

HELEN
KELLER
MEMORIAL HOSPITAL

October 19, 1987

Mr. William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

Dear Mr. Roper:

Helen Keller Memorial Hospital in Sheffield, Alabama supports and shares HCFA's interest in the quality of care delivered in our nation's hospitals. However, we do not believe that the HCFA mortality data, when taken alone, measures a hospital's performance or quality.

The statistical model used by HCFA to measure quality of care showed that Helen Keller Memorial Hospital provides a high level of quality care in every category studied by HCFA. We believe this to be a fact. However, a faulty statistical model could have taken these facts and reported incorrect findings. Therefore, the testing of any statistical model is key to ensuring accurate and reliable results. There is no evidence to indicate that your model has been validated as a reliable indicator of quality. Therefore, we consider it fortunate that in our case your model worked properly by, correctly reporting that Helen Keller Memorial Hospital provides a high level of quality of care.

We also believe that the mortality data cannot be used as a provider of a hospital's mortality rate. The model fails to consider a wide range of factors that have a significant impact on mortality such as a patient's overall health status, the stage of a patient's illness, the patient's psychological condition, family support and many other socioeconomic factors.

P.O. Box 610
Sheffield, Alabama 35660
205-386-4196

The data used by HCFA indicates that a total of 130 Medicare patients admitted to Helen Keller Memorial Hospital died within 30 days of admission. (Please see Attachment A for corrections which we made to some of the HCFA data which our records indicated were inaccurate). Our analysis of the HCFA data revealed that of the 130 patients who died, 100 were admitted with high risk diagnoses such as cancer, stroke, severe acute heart disease, severe chronic heart disease, gastrointestinal catastrophes, metabolic and electrolyte disorders, pulmonary disease, renal disease, sepsis and severe trauma. In addition, the average age of these patients was 75 years. Unfortunately, patients with these characteristics often have poor prognoses for recovery even in the presence of high quality health care such as that which is delivered at Helen Keller Memorial Hospital.

Further analysis revealed that the remaining 30 of the 130 Medicare patients were admitted with low risk or "other" principal diagnoses. However, a review of these patients' records showed that most had significant underlying complications such as septic shock, end stage renal disease, respiratory failure and congestive heart failure. Also, the average age of these patients was 77 years. As with high risk patients, the probability of recovery among these low risk patient was not favorable given the patient's age and over medical condition.

In summary, HCFA's interest in measuring quality in health care is commendable. However, the methodology used by HCFA to measure quality is unproven and has serious limitations. Any conclusions drawn from HCFA's methodology can be very misleading and should only be considered after a more thorough examination of the facts.

Respectfully,



J. Randall Phillips
Vice President
Helen Keller Memorial Hospital

ATTACHMENT A

<u>Patient ID Number (HIC)</u>	<u>Sumate (First 6 ltrs)</u>	<u>Diagnostic Category</u>	<u>AGE</u>	<u>SEX</u>	<u>Date of Admission</u>	<u>Date of Discharge</u>	<u>Date of Death</u>	<u>Principal Diagnosis</u>	<u>Principal Procedure</u>
[REDACTED]	[REDACTED]	SE	078	F	02/01/86	02/02/86	02/02/86	03849	9960

AUM Access Road
P O Box 17720
Montgomery Alabama
36193-4201
Telephone 205 277-6330

Humana Hospital East Montgomery

October 26, 1987

William L. Roper, M.D.
Administrator, Health Care
Financing Administration
Department of Health and Human Services
Attention: HSQ-148-GNC
P.O. Box 26676
Baltimore, Maryland 21201

Dear Dr. Roper:

Thank you for the opportunity to comment on the mortality data for our hospital provided to us last month. We support HCFA's desire to educate those interested in Medicare quality issues. Although this program is in its early developmental stages and while its measurements are preliminary and rough, we realize that this is an example of the type of quality measurements that we will see in the future.

As you are aware, being accredited by the Joint Commission on Accreditation of Health Organizations and other outside review organizations, that we are already doing complete review of all admissions which result in patient mortality, regular morbidity and mortality reviews, quality assurance, utilization review, as well as other reviews. This information that you are providing us is helpful in enhancing our quality assurance program here.

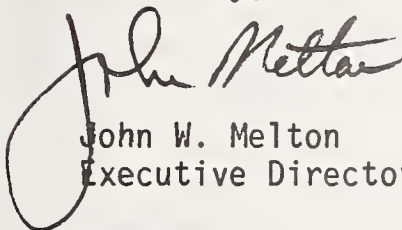
Since these numbers that you provided to us reflect only the deaths in a very limited segment of our hospital's patient population (the elderly) and are not adjusted for severity of illness or factors which may affect patient outcome, they must be considered in that context and should serve only as one of the numerous indicators used to review the quality of services provided at an individual hospital. While this statistical data is useful in this format for professional evaluation it is not beneficial for consumer use. As a result, consumers should be informed as to the limited scope of these numbers and be cautioned about drawing any conclusions from the data about the quality of a particular hospital's services.

As in all deaths occurring in hospitals, a complete internal review is necessary to determine the appropriateness of the outcome and may provide information to physicians and other medical providers about improvements that can be made in treating future patients. Thus, the use of raw mortality statistics is helpful to professionals in identifying patient trends and treatment outcomes and we will be providing this information to our medical staff for this purpose. I hope that there is some way in which our consumers have a better understanding of the extensive quality control systems in place in hospitals.

Our hospital's quality assurance department has reviewed the data and after a complete analysis, this information will be given to our medical staff's Executive Committee and then passed on through the rest of the medical staff. Generally we have found data to be consistent with our hospital records. Unfortunately, in most cases the number of patients in a particular category is too small to provide a valid statistical analysis.

I hope this information will be helpful in attempting to refine the collection and reporting of raw hospital data. In addition, our hospital will do everything possible to assist our community in understanding how this data can be best used to improve health care services.

Sincerely,

A handwritten signature in dark ink, appearing to read "John W. Melton". The signature is fluid and cursive, with a large loop at the beginning.

John W. Melton
Executive Director

JWM/pkc

Humana Hospital Enterprise

October 26, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Sirs:

Thank you for the opportunity to comment on the hospital specific mortality data provided to us late last month. Humana Hospital - Enterprise supports the Health Care Financing Administration's desire to educate those interested in Medicare quality issues. We recognize this program is early in its development stages. While its measurements are preliminary and rough, it is clearly an example of the type of quality measurements to come.

This information is helpful in our hospital's ongoing quality assurance program that includes regular and complete review of all admissions which result in patient mortality, regular morbidity and mortality reviews, quality assurance, utilization review, as well as complete outside review by the Joint Commission on Accreditation of Health Organizations and other outside review organizations.

Since these raw numbers reflect deaths which occurred in only a limited segment of a hospital's patient population (the elderly) and are not adjusted for severity of illness or other factors which may affect patient outcome, they must be considered in that context and should serve as only one of numerous indicators used to review the quality of services provided at an individual hospital. While this statistical data is useful in this format for professional evaluation, it is not beneficial for consumer use. As a result, consumers should be informed as to the limited scope of these numbers, and be cautioned about drawing any conclusions from the data about the quality of a particular hospital's services.

As in all deaths occurring in hospitals, a complete internal review is necessary to determine the appropriateness of the outcome and may provide information to physicians and other

October 26, 1987

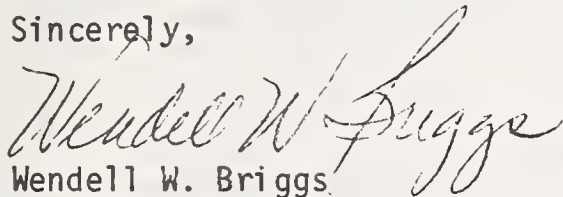
Page 2

medical providers about improvements which can be made in treating future patients. Thus, the use of raw mortality statistics is helpful to professionals in identifying patient trends and treatment outcomes. Additionally, they may assist health care consumers in understanding the extensive quality control system in place in hospitals.

Our hospital's quality assurance and utilization review departments have reviewed the data. Since some deaths occurred outside the hospital, we have been unable to completely validate this data. Generally, we have found it to be consistent with some exceptions with our hospital records. Unfortunately, in most cases the number of patients in a particular category is too small to provide a valid statistical analysis. In addition, the predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner, it would be inappropriate to consider them acceptable or unacceptable "standards".

We hope this information will be helpful in attempting to refine the collection and reporting of raw hospital data. In addition, our hospital will do everything possible to assist our community in understanding how this data can best be used to improve health care services.

Sincerely,



Wendell W. Briggs
Executive Director

WWB/mn

2111 Cloyd Boulevard
P.O. Box 2010
Florence, Alabama
35030
Telephone 205 767-8748

Humana Hospital Florence

October 23, 1987

William L. Roper, M.D.
Administrator, Health Care
Financing Administration
Department of Health and Human Services
Attention: HSQ-148-GNC
P.O. Box 26676
Baltimore, Maryland 21201

Dear Dr. Roper:

We have received the mortality data for our hospital. Thank you for the opportunity to comment on the hospital specific mortality data provided to us late last month. Humana Hospital Florence supports the Health Care Financing Administration's desire to educate those interested in Medicare quality issues. We recognize this program is early in its development stages. While its measurements are preliminary and rough, it is clearly an example of the type of quality measurements to come.

Our hospital's ongoing quality assurance program includes regular and complete review of all admissions which result in patient mortality. Additionally, the regular quality assurance program includes utilization review, Infection Control, Tissue and Transfusion review as well as complete outside review by the Joint Commission on Accreditation of Health Organizations and other outside review organizations.

Since these raw numbers reflect deaths which occurred in only a limited segment of a hospital's patient population (the elderly) and are not adjusted for severity of illness or other factors which may affect patient outcome, they must be considered in that context and should serve as only one of numerous indicators used to review the quality of services provided at an individual hospital. While this statistical data is useful in this format for professional evaluation, it is not beneficial for consumer use. As a result, consumers should be informed as to the limited scope of these numbers, and be cautioned about drawing any conclusions from the data about the quality of a particular hospital's services.

October 21, 1987

As in all deaths occurring in hospitals, a complete internal review is necessary to determine the appropriateness of the outcome and may provide information to physicians and other medical providers about improvements which can be made in treating future patients. Thus, the use of raw mortality statistics is helpful to professionals in identifying patient trends and treatment outcomes. Additionally, they may assist health care consumers in understanding the extensive quality control systems in place in hospitals.

Our hospital's quality assurance committee has reviewed the data. Since some deaths occurred outside the hospital, we have been unable to completely validate this data. Generally, we have found it to be consistent with some exceptions with our hospital records. Unfortunately, in most cases the number of patients in a particular category is too small to provide a valid statistical analysis. In addition, the predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner, it would be inappropriate to consider them acceptable or unacceptable "standards".

Again, in summary the main points I wish to emphasize are:

- 1) The hospital has an internal quality assurance program which reviews not only hospital deaths but many facets of hospital care.
- 2) The data as released should be adjusted by hospital severity of illness.
- 3) This statistical data is not beneficial for consumer use.

I hope this information will be helpful in attempting to refine the collection and reporting of raw hospital data. In addition, our hospital will do everything possible to assist our community in understanding how this data can best be used to improve health care services.

Sincerely,



W. M. Donohoo, FACHE
Executive Director

WMD/ss

Jackson Highway Bypass
PO Box 1069
Russellville Alabama
35663
Telephone 205 332-1611

 **Humana Hospital
Russellville**

October 26, 1987

MEDICARE Provider #
01-0094

William L. Roper, M.D.
Administrator
Health Care Financing Administration

Dear Dr. Roper:

This letter is in response to your invitation to comment on the Health Care Financing Administration (HCFA) mortality data concerning Medicare patients treated at Humana Hospital Russellville in 1986. The intention of this report to identify the level of quality care for the provider is admirable, however, the method of study is complex and can be very misleading to the public.

Humana Hospital - Russellville has many ongoing mechanisms in place to assure a high level of care is delivered to our patients including continuous complete review of all patient mortality and quality assurance monitoring for each department and all medical services. Humana Hospital - Russellville is fully accredited by the Joint Commission on Accreditation of Health Care Organizations which monitors not only the outcome but also the process and procedure of the entire hospital operation to assure the optimal level of care is provided.

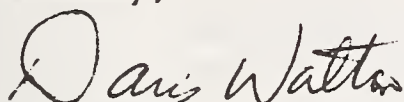
The data supplied by HCFA is of course limited in that it reflects only the hospital's Medicare population and is not adjusted to account for severity of illness or other factors which may affect patient outcomes. This information can be considered useful for our monitoring purposes, but also very misleading and of little benefit to the public. The public should be informed as to the limited scope of these numbers, and be cautioned about drawing conclusions from the data about the quality of a particular hospital's services.

Dr. William L. Roper
October 26, 1987
Page Two

The mortality data supplied by HCFA for Humana Hospital Russellville has been reviewed by our Medical Records and Quality Assurance Departments. This data is generally consistent with hospital records, however, it is impractical to validate data on deaths occurring outside the hospital. Furthermore, in most cases the number of patients in a given category may be too small to provide a valid statistical analysis, and the predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner, it would be inappropriate to consider them acceptable standards.

Thank you for the opportunity to comment on this information. Humana Hospital - Russellville is dedicated to providing the highest level of care to our service area, and we will do everything possible to assist the public in understanding this data.

Sincerely,

A handwritten signature in cursive script that reads "Davis Walton".

Davis Walton
Executive Director

DW/bj

911 Big Cove Road
Huntsville, Alabama
35601
Telephone 205 532-5600

Humana Hospital Huntsville

October 26, 1987

Department of Health & Human Services
Health Care Financing Administration
6325 Security Boulevard
Baltimore, Maryland 21207

Attn: William S. Roper, M.D.

Subject: RESPONSE TO HCFA ON HOSPITAL MORTALITY RATES

Dear Dr. Roper:

Thank you for the opportunity to comment on the hospital specific mortality data provided to us late last month. Humana Hospital - Huntsville supports the Health Care Financing Administrator's desire to educate those interested in Medicare quality issues. I recognize this program is early in its development stages. While its measurements are preliminary and rough, it is clearly an example of the type of quality measurements to come.

This information is helpful in our hospital's ongoing quality assurance program. Our program includes regular and complete review of all admissions which result in patient mortality, regular morbidity and mortality reviews, quality assurance, utilization review, as well as complete outside review by the Joint Commission on Accreditation of Health Organizations and other outside review organizations.

Since these raw numbers reflect deaths which occurred in only a limited segment of a hospital's patient population (the elderly) and are not adjusted for severity of illness or other factors which may affect patient outcome, they must be considered in that context and should serve as only one of numerous indicators used to review the quality of services provided at an individual hospital. While this statistical data is useful in this format for professional evaluation, it is not beneficial for consumer use. As a result, consumers should be informed as to the limited scope of these numbers, and be cautioned about drawing any conclusions from the data about the quality of a particular hospital's services.

Gene B. Wright
October 26, 1987
Page 2

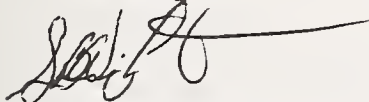
As in all deaths occurring in hospitals, a complete internal review is necessary to determine the appropriateness of the outcome and may provide information to physicians and other medical providers about improvements which can be made in treating future patients. Thus, the use of raw mortality statistics is helpful to professionals in identifying patient trends and treatment outcomes. Additionally, they may assist health care consumers in understanding the extensive quality control systems in place in hospitals.

Our hospital's Quality Assurance Committee has reviewed the data. Since some deaths occurred outside the hospital, we have been unable to completely validate this data. Generally, we have found it to be consistent (with some exceptions) with our hospital records. Unfortunately, in most cases the number of patients in a particular category is too small to provide a valid statistical analysis. In addition, the predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner, it would be inappropriate to consider them acceptable or unacceptable "standards."

Specifically, we reviewed all categories and find that under categories GC (gastrointestinal catastrophes); HM (severe chronic heart disease); HS (severe acute heart disease); ME (metabolic/electrolyte disturbances); SE (Sepsis); and TR (Trauma) the above mentioned variances cause particular disadvantageous skewing of evaluative information.

I hope this information will be helpful in attempting to refine the collection and reporting of raw hospital data. In addition, our hospital will do everything possible to assist our community in understanding how this data can best be used to improve health care services.

Sincerely,



Gene B. Wright
Associate Executive Director

/m



HUNTSVILLE HOSPITAL

101 Sivley Road • Huntsville, Alabama 35801 • 205/533-8020

October 1987

Comments on HCFA's Mortality Data
from Huntsville Hospital, Huntsville, Alabama

Huntsville Hospital has thoroughly reviewed the Health Care Financing Administration Mortality Data and found that, with minor exceptions, the statistics are accurate.

While HCFA's review of mortality data is an important first step towards attempts to measure healthcare quality, it is important to note that this is but one of many indicators of hospital quality. The medical staff at Huntsville Hospital monitors mortality data and has an active system for gathering feedback from patients and physicians as a part of our own comprehensive quality assurance program. We maintain continuous efforts to identify opportunities to improve care.

The administration and medical staff at Huntsville Hospital encourage consumer interest in valid and useful information concerning the quality of care available to them.

This hospital has served the North Alabama area for almost 100 years. It is a 578-bed acute care facility and while it is a public institution, it is self-supporting and receives no state or federal tax support funds.

Cordially,

Edward D. Boston
Chief Executive Officer
Huntsville Hospital

E. E. Litkenhous, M.D.
Chief of Staff
Huntsville Hospital

/apc

Knollwood Park Hospital

5600 Girby Road
Post Office Box 9753
Mobile, Alabama 36691
Tel. (205) 661-5020

October 26, 1987

Department of Health and Human Service
Health Care Financing Administration
Mortality Data
Washington, D.C. 20201

RE: KNOLLWOOD PARK HOSPITAL
MEDICARE PROVIDER #010152

To Health Care Financing Administration
Comments on the HCFA Mortality Data

We have received and reviewed the selected Mortality Data due for publication in December 1987. In reviewing our own data we find with a few exceptions it appears to be basically correct (see attachment for areas of disagreement) All DRG categories were in acceptable range. One patient died in the hospital rather than after discharge as indicated. [REDACTED] It is very difficult to determine number of deaths after discharge or reason for deaths. Some were obvious because of terminal or chronic disease.

We would like to address some **Generic Observations**:

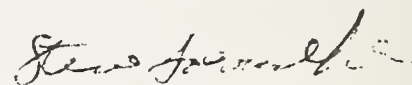
- This data does not take into consideration patients with terminal diseases not appropriate for continued hospital stay. Discharge DRG reflects illness which caused admission not terminal disease. Example: patient coded ME yet had terminal CA. Death in this instance could be misleading and indicate premature discharge.
- Patients death within thirty days of discharge may be due to unrelated problems such as a motor vehicle accident or other acute trauma.
- Prior to June, 1984, inflated numbers of acute care admissions caused mortality figures to be somewhat diluted as compared to mortality rates under the PPS guidelines. Now with intensive admission review criteria and resultantly decreased numbers of appropriate acute care admissions, mortality rates appear higher.

- Predictably all births will result in deaths after some period of time since death is an outcome of life. Mortality figures that fail to identify severity of illness at time of the last admission in an acute care setting simultaneously fail to accurately describe anything but a predictable happenstance.
- Lastly but of great importance is the legal fishbowl in which hospitals have to operate. Lawsuits have fostered the expectation that all illness will have a good outcome. By using mortality as a measure of care HCFA may appear to endorse this belief.

While understanding HCFA's concern regarding quality of care, we would encourage you to continue to develop a model which can more accurately measure quality performance in a hospital. In our opinion, mortality rates are not adequate tools to judge quality of care.

Thank you for giving us an opportunity to review this data prior to publication.

Sincerely,



Steve Loescher
Administrator

SL:mh

010152

KCH

Worksheet 1: Analysis of Reporting Errors

Diagnostic Category	Deaths Reported by HCFA		Deaths Verified by Hospital	
	In-hospital	Post-hospital	In-hospital	Post-hospital
CA -- Cancer	1	5	1	5
CE -- Cerebrovascular Accidents	2	1	2	1
GC -- Gastrointestinal Catastrophes	3	1	3	1
GI -- Gastrointestinal Disease	7		7	
GU -- Urologic Disease	2		2	
GY -- Gynecologic Disease	2		2	
HL -- Low Risk Heart Disease	2		2	
HM -- Severe Chronic Heart Disease	8		8	
HS -- Severe Acute Heart Disease	11	1	12	2
ME -- Metabolic/Electrolyte Disturbances	2		2	
OP -- Orthopedic Disorders	1		1	
PN -- Pulmonary Disease	11	1	11	1
RN -- Renal Disease	1		1	
SE -- Sepsis	1		1	
TR -- Severe Trauma	2	1	2	1
OP -- Ophthalmologic Disease	2		2	
UN -- Other Diagnoses	4	3	4	3
Total -- All Categories	54	13	55	12

NOTES: In the Deaths reported by HCFA, tabulate the number of deaths assigned to each diagnostic category on the individual care listing. In-hospital deaths are those patients whose date of discharge is the same as the date of death; post-hospital deaths are those patients whose date of death is after the date of discharge. Verified deaths should include those patients who are known to have died or whose status 30-days after discharge from the hospital cannot be determined. Verified deaths should also exclude patients that the hospital does not believe were ever admitted to the hospital.

COMMENTS ON THE HCFA MORTALITY DATA

Lakeshore Community Hospital, Dadeville, Alabama

INTRODUCTORY COMMENTS

While we support HCFA's interest and concern about the quality of hospital care, we feel that the HCFA mortality data are not, in themselves, measures of a hospital's performance or quality. The testing of any statistical model is key to ensuring accurate results and no evidence indicates that this model has been validated as an indicator of quality.

We also feel that the mortality data cannot be used as a predictor of a hospital's mortality rate. The model fails to consider a wide range of factors that have a significant impact on mortality which include the patient's general health status, the stage of patient's illness, the patient's psychological condition, family support and many other socio-economic factors.

DATA VERIFICATION

The data used by HCFA indicates that a total of 30 Medicare patients admitted to Lakeshore Community Hospital died within 30 days of admission. Of these, 21 died while still a patient of the hospital, while 9 died after discharge. Our own records indicate that 420 Medicare admissions occurred in 1986. Presumably the discrepancy reflects multiple admissions of individual beneficiaries. Our own records indicate that of the 22 Medicare (22) patients who died within 30 days of admission while still an inpatient 8 were still alive at the time of discharge. One was transferred to another acute care facility, 1 was transferred to a VA medical center, 4 were discharged to nursing homes and 2 were discharged home. It is impossible to determine the percentage of the 8 patients dying after discharge who were in fact alive, as information concerning death after discharge is not included in the patient's medical record.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

INTERPRETIVE REMARKS

After correcting the errors in the recording of deaths, actual overall predicted mortality rate falls to 9%. Cancer mortality decreases to 44%, Cerebrovascular Accidents mortality decreases to 0%, Pulmonary Disease decreases to 8%.

RESULTS OF PRELIMINARY MEDICARE RECORD REVIEW

Many of the patients who died had numerous complicating factors that developed after admission. For example in category HL (Low-Risk Heart Disease) patient Trimble 424 12 7539 A, came in to the hospital with angina, had a CVA after admission and also developed pneumonia. The methods used by HCFA seem to be based on principal diagnosis or reason for admission to the hospital and not the complexity or severity of patient's illness. This would seem to invalidate the mortality diagnostic categories. Furthermore, many of the patients who died were residents of nursing homes who had varying stages of chronic illnesses in addition to their acute illness.

Rita Smith

Rita Smith, RN
DRG/UR Coordinator

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

Worksheet 1: Analysis of Reporting Errors

Diagnostic Category	Deaths Reported by HCFA		Deaths Verified by Hospital*		Transfer		
	In-hospital	Post-hospital	In-hospital	Home	Nursing Home	VA Med Ctr.	Acute Care
CA -- Cancer	4	1	4	1	1		
CE -- Cerebrovascular Accidents	0	1	0				
GC -- Gastrointestinal Catastrophes	3	0	3	0			
GI -- Gastrointestinal Disease	1	1	2	0			
GU -- Urologic Disease	1	0	1	0			
GY -- Gynecologic Disease	0	0	0	0			
HL -- Low Risk Heart Disease	1	0	1	0			
HM -- Severe Chronic Heart Disease	2	0	2	0			
HS -- Severe Acute Heart Disease	2	0	2	0			
ME -- Metabolic/Electrolyte Disturbances	0	0	0	0			
OP -- Orthopedic Disorders	0	0	0	0			
PN -- Pulmonary Disease	3	4	3	1	2	1	
RN -- Renal Disease	0	0	0	0			
SE -- Sepsis	0	0	0	0			
TR -- Severe Trauma	0	0	0	0			
OP -- Ophthalmologic Disease	0	0	0	0			
UN -- Other Diagnoses	4	2	4	0	1	0	1
Total -- All Categories	21	9	22	2	4	1	1

AL 91.1

NOTES: In the Deaths reported by HCFA, tabulate the number of deaths assigned to each diagnostic category on the individual care listing. In-hospital deaths are those patients whose date of discharge is the same as the date of death; post-hospital deaths are those patients whose date of death is after the date of discharge. Verified deaths should include those patients who are known to have died or whose status 30-days after discharge from the hospital cannot be determined. Verified deaths should also exclude patients that the hospital does not believe were ever admitted to the hospital.

HOSPITAL - 010052	LAKESHORE COMMUNITY HOSP	DADEVILLE AL				
DIAGNOSTIC CATEGORY	CASES	ACTUAL MORTALITY RATE	ACTUAL CORRECTED MORTALITY RATE	RANGE OF PREDICTED MORTALITY RATES		
ALL CAUSES	244	12 Z	9%	7	17 Z	
CA - CANCER	9	56 Z	44%	13	70 Z	
CE - CEREBROVASCULAR ACCIDENTS	11	9 Z	0%	8	57 Z	
CC - GASTROINTESTINAL CATASTROPHES	5	* 60 Z		2	69 Z	
CI - GASTROINTESTINAL DISEASE	32	6 Z		2	23 Z	
CU - UROLOGIC DISEASE	6	17 Z		0	64 Z	
HL - LOW-RISK HEART DISEASE	23	4 Z		1	26 Z	
HM - SEVERE CHRONIC HEART DISEASE	41	18 Z		5	51 Z	
HS - SEVERE ACUTE HEART DISEASE	7	29 Z		8	70 Z	
ME - METABOLIC/ELECTROLYTE DISTURBANCES	9	0 Z		1	53 Z	
OP - ORTHOPEDIC DISORDERS	10	0 Z		0	77 Z	
PN - PULMONARY DISEASE	39	18 Z	8%	8	33 Z	
SE - SEPSIS	2	0 Z		4	93 Z	
TR - SEVERE TRAUMA	1	0 Z		0	99 Z	

* In category GC - Gastrointestinal Catastrophes:

In all three cases, patients had numerous complications.

1. [REDACTED] - [REDACTED] refused surgery. [REDACTED] also had severe pulmonary fibrosis, CHF and renal failure.
2. [REDACTED] - [REDACTED] was admitted with Upper GI bleeding which was controlled. Required exploratory surgery after experiencing bile leak secondary to liver biopsy. [REDACTED] was found to have a bile duct hemartoma of liver and developed Peritonitis.
3. [REDACTED] was admitted with Upper GI bleeding which was controlled. Patient developed thrombo-embolism with respiratory and cardiac arrest. [REDACTED]



701 Lloyd Noland Parkway, Fairfield, AL., 35064 205/783-5121

October 7, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Lloyd Noland Hospital & Health Centers welcomes the opportunity to comment on the Health Care Financing Administration's mortality data. We applaud HCFA's efforts to seek hospital comments throughout the development of this study on both the methodology and data it generated. In particular, we appreciate having some time to analyze and comment on the data prior to its final release.

After reviewing the HCFA data, Lloyd Noland Hospital continues to question the use of mortality rates as an indicator of quality. This is a relationship which has not been validated. Moreover, we find the study contains serious flaws which severely limit its ability to predict reliable hospital mortality rates. The absence of socio-economic factors is perhaps the most glaring flaw, as lifestyle and occupation, strongly influence the health of our patients.

This study attempts the impossible - using a very limited number of variables to predict appropriate mortality rates. And, the study goes a step further by implying that variance from these ranges reflects inadequate quality of care. Quality and mortality are multifaceted and cannot be measured in such a fashion. Using mortality rates, even ones which might be based on valid data, is considering only a part of the picture.

The study also is seriously flawed by the use of principal diagnosis to categorize deaths. Using the principal diagnosis may obscure the exact cause of death. In fact, the coding system itself is designed to code principal diagnosis not death diagnosis. A careful review by our physicians of each death chart used by HCFA in three categories revealed numerous instances in which the principal diagnosis was not used and other cases in which the principal diagnosis did not reflect the cause of death. For example, a patient who died due to an upper GI bleed was included in the Metabolic/Electrolyte Disorders category. Obviously, the incorrect code was selected from the charts as the death diagnosis.

Further, the methodology fails to account for numerous factors greatly affecting the death of a patient after discharge. Such a death may reflect inadequate or poor care by non-hospital providers, a lack of appropriate care, or a patient's noncompliance with prescribed medical treatment. Also unaccounted for are unrelated health conditions, accidents and other circumstances. Lack of such factors skews the resulting data.

DATA VERIFICATION

Lloyd Noland Hospital & Health Centers personnel have discovered numerous flaws in the mortality data used by HCFA for the 1987 mortality study. The discrepancies include inaccurate death dates, sex, age and ICD-9CM codes for Lloyd Noland Hospital patients. Such discrepancies cast doubt on the accuracy of the data which HCFA asks hospitals, Peer Review Organizations and consumers to use as an indicator of quality.

In addition to these flaws, we also have noted a tremendous variation between total number of Medicare cases used in the study and the total number of Medicare patients we admitted. While a small portion of this variation may be explained based on the HCFA selection process (using the last admission and deaths within thirty days), we cannot logically account for the vast difference. We can only assume that HCFA used selected data in its study and failed to notify hospitals of their data selection criteria. Moreover, because the entire data base used was not made available to hospitals, it is impossible to verify which cases were involved in the study.

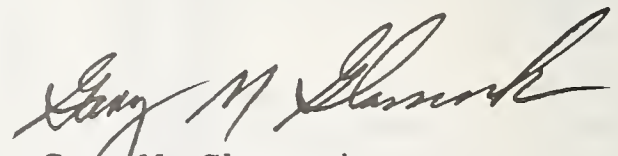
In our review of death charts, we have become increasingly concerned with HCFA's use of mortality data as a quality indicator. Mortality data does not begin to address critical individual differences among cases. For example, one medical death at Lloyd Noland Hospital involved an eighty-eight year old woman who was being transferred from her home to a nursing home via ambulance. En route to the nursing home, she had a cardiac arrest and was brought to the closest hospital-Lloyd Noland. She had never before been a patient at Lloyd Noland Hospital. She was admitted through the Emergency Department to our Cardiac Care Unit and died less than three hours later. The rest of the story HCFA knows.

SUMMARY

While Lloyd Noland Hospital supports HCFA's goal to provide useful information to Peer Review Organizations and the public, the 1987 mortality study falls far short of achieving this. Rather than yielding valid information, it attempts to suggest quality based upon unreliable data. While death charts are thoroughly reviewed by medical and quality assurance personnel, we do not measure quality of care simply by the number of deaths which occur. Like most hospitals, we have numerous mandated and voluntary quality assurance activities which range from appropriateness of care indicators to patient satisfaction surveys. We suggest HCFA carefully examine the use of more reliable and accepted measures of quality, particularly in light of the inaccurate data base used in this study.

Sincerely,


Leon C. Hamrick, M.D.
Medical Director


Gary M. Glasscock
Administrator

LCH/GMG:jc



October 20, 1987

William L. Roper, M.D.
Administrator
Healthcare Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

RE: Mortality Data - 010044

Dear Dr. Roper:

Our comments regarding the HCFA mortality data are:

1. Each mortality is reviewed by the hospital's Quality Assurance Committee with results reported to the Medical Staff Executive Committee. There were no unexpected occurrences of mortality in the hospital during the year.
2. The hospital has an attached 69 bed nursing home whose average age and expected longevity greatly affect the number of mortalities at this facility.
3. The average age of the mortalities during 1986 was eighty (80) years old and they represented only 2.5% of the total number of admissions treated during the year.
4. Forty two of the forty three mortalities were over sixty five (65) years old and three fourths of the mortalities at the hospital were over seventy (70) years old.
5. The one statistical category, Severe Acute Heart Disease, where a significant percentage fell outside the range for mortality showed us an average age of eighty (80) years old. Again, this is important because the hospital adjoins a nursing home. No cases were found to have unexpected outcome.
6. The only statistical mortality that was under the age of sixty five (65) was a thirty four (34) year old, severe diabetic, whose death occurred eight (8) days



after discharge from the hospital, and was attributed to an unrelated cause.

7. The second significant category of mortalities was cancer. These patients ranged from sixty five (65) to eighty nine (89) years old with the average age at mortality being seventy five (75). No cases were found to have unexpected outcomes.
8. Patient mortalities treated for Cerebrovascular Accidents (Strokes) and Pulmonary Disease totaled eight with an average age at death of ninety two (92) and seventy eight (78) respectively.
9. It should be noted that mortality statistics have no direct correlation to quality of care. The ranges of data used do not consider any circumstances of the seriousness of patient's condition at admission, specialties of the hospitals, or demographics of the population served. Comparing facilities would be like comparing one species to another unrelated species.

Because of the above, we believe the efforts expended compiling, publishing and explaining such statistics is gross mismanagement of public monies. We further believe that tax payers money could be spent in better ways other than using such in-urbane methods to criticize the best healthcare system in the world today.

Sincerely,

A handwritten signature in dark ink, appearing to read 'W. Douglas Arnold'.

W. Douglas Arnold
Administrator
Marion County General Hospital

WDA/lb

CC

8EASTERN 8HEALTH 8SYSTEM, INC.

28 October 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

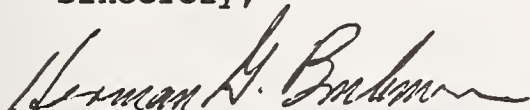
Medical Center East has reviewed the mortality data provided by HCFA with correspondence dated September 21, 1987. While we support HCFA's interest and concern about the quality of hospital care, we feel that the HCFA mortality data are not, by themselves, measures of an individual hospital's performance or quality of patient care. We feel mortality data cannot be used as an accurate prediction of a hospital's mortality rate.

The data furnished by HCFA has been reviewed by our Medical Records department and we have found 39 discrepancies which need reconciliation (see attached). We have listed the data provided by HCFA and below noted with an asterisk is the datum from our records. You will note that we have no record of one of the patient deaths as listed in the HCFA data.

Although these discrepancies only equal some ten-plus percent of the total, we suggest HCFA carefully examine the use of more reliable measures of quality, particularly in light of the inaccurate data base used in this study.

If you have any questions concerning this correspondence please contact me at (205) 838-3988.

Sincerely,



Herman G. Brehmer
Vice President
Corporate Development

HGB/hg

<u>PT ID</u>	<u>NAME</u>	<u>DC</u>	<u>AGE</u>	<u>SEX</u>	<u>ADMIT</u>	<u>DISCHARGE</u>	<u>EXPIRED</u>	<u>DX.</u>	<u>PROC</u>	
[REDACTED]	[REDACTED]	CA	082 080*	M	04/23/86	04/25/86	04/25/86	1623		
[REDACTED] *****	[REDACTED] *****	CA **	085 ***	F *	12/04/86 *****	12/12/86 *****	12/31/86 *****	1830 ****	4292 ****	NO RECORD OF PATIENT
[REDACTED]	[REDACTED]	CA	071 070*	F	05/28/86	05/30/86	05/30/86	1623	8954	
[REDACTED]	[REDACTED]	CA	098 096*	F	03/02/86	03/04/86	03/31/86	179	8876	
[REDACTED]	[REDACTED]	CA	079 080*	F	03/26/86	04/16/86	04/16/86	1977	5011	
[REDACTED]	[REDACTED]	CE	082	M	06/28/86 07/14/86*	07/21/86	07/23/86	436	9339	
[REDACTED]	[REDACTED]	CE	091 092*	M	01/30/86	02/07/86	02/07/86	436	8703	
[REDACTED]	[REDACTED]	CE	094 093*	F	06/04/86	06/09/86	06/19/86	436	8703	
[REDACTED]	[REDACTED]	CE	057	M	06/26/86	07/12/86 07/13/86*	07/12/86 07/13/86*	4349	311	
[REDACTED]	[REDACTED]	CE	060	F	11/11/86	11/23/86	11/22/86 11/23/86*	436	3927	
[REDACTED]	[REDACTED]	GC	076	F M*	11/29/86	12/02/86	12/21/86	5789		
[REDACTED]	[REDACTED]	GC	075 067*	F	05/23/86	05/24/86	05/24/86	5789	8954	
[REDACTED]	[REDACTED]	GI HS*	060	F	05/18/86 06/07/86*	05/28/86 06/18/86*	06/17/86 06/18/86*	5589 4111*	3995	
[REDACTED]	[REDACTED]	HL	087 085*	F	09/08/86	09/15/86	09/15/86	4039	8954	
[REDACTED]	[REDACTED]	HM	088 037*	F	01/01/86	04/17/86	04/30/86	4254	4824	
[REDACTED]	[REDACTED]	HM	073 074*	M	01/16/86	01/30/86	01/30/86	4280	8954	
[REDACTED]	[REDACTED]	HS	081	M	06/23/86	06/30/86 07/01/86*	06/30/86 07/01/86*	4275	9392	
[REDACTED]	[REDACTED]	HS	075	M	05/13/86	05/14/86 05/13/86*	05/13/86	4101	9604	
[REDACTED]	[REDACTED]	HS	076 077*	F	05/19/86	05/20/86	05/20/86	4100	9604	
[REDACTED]	[REDACTED]	HS	080 081*	F	05/10/86	05/14/86	05/14/86	4107	8954	
[REDACTED]	[REDACTED]	HS	075 074*	F	05/28/86	05/29/86	05/29/86	4101	9604	
[REDACTED]	[REDACTED]	HS	073 074*	F	01/01/86	01/04/86	01/04/86	4104	8856	
[REDACTED]	[REDACTED]	HS	068 067*	M	08/07/86	08/07/86	08/07/86	4104	8954	
[REDACTED]	[REDACTED]	PN	093 094*	M	02/16/86	02/17/86	02/17/86	486		

[REDACTED]	[REDACTED]	PN	076 074*	M	05/12/86	05/13/86	05/13/86	496	9604
[REDACTED]	[REDACTED]	PN	072 073*	M	02/12/86	02/23/86	02/23/86	49390	8954
[REDACTED]	[REDACTED]	PN ME*	076 11/06/86*	M	10/26/86 11/06/86*	10/31/86 11/09/86*	11/04/86 11/09/86*	5119 2765*	5491
[REDACTED]	[REDACTED]	RN	085 083*	M	09/10/86	09/18/86	09/04/86	586	6011
[REDACTED]	[REDACTED]	SE	084 085*	F	09/09/86	09/15/86	09/30/86	0381	
[REDACTED]	[REDACTED]	SE	089 084*	F	04/14/86	04/16/86	04/16/86	0380	8954
[REDACTED]	[REDACTED]	SE	069 070*	M	03/05/86	03/05/86	03/05/86	0389	
[REDACTED]	[REDACTED]	SE	076 075*	F	04/12/86	04/15/86	05/11/86	0381	8742
[REDACTED]	[REDACTED]	UN	080 085*	F	05/28/86	05/30/86	06/21/86	4402	
[REDACTED]	[REDACTED]	UN	089	F	12/21/86	12/22/86	12/21/86 12/22/86*	4440	
[REDACTED]	[REDACTED]	UN	086 085*	F	09/11/86	09/14/86	09/14/86	4440	8954
[REDACTED]	[REDACTED]	UN	086 077*	F	08/18/86	08/22/86	09/07/86	4540	8622
[REDACTED]	[REDACTED]	UN	070 071*	M	05/12/86	05/31/86	05/31/86	4439	3808
[REDACTED]	[REDACTED]	UN	086 087*	F	01/01/86	01/02/86 01/01/86*	01/02/86 01/01/86*	2849	9962
[REDACTED]	[REDACTED]	UN	084 085*	M	07/14/86	07/15/86	07/31/86	87349	

* EQUALS CORRECTED DATA

MOBILE INFIRMARY
POST OFFICE BOX 2144

MEDICAL CENTER
MOBILE, ALABAMA 36652

October 23, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
Post Office Box 26684
Baltimore, Maryland 21207

Gentlemen:

Thank you for providing us with statistical data comparing the actual mortality rate of Mobile Infirmary with predicted mortality rates in a number of diagnostic categories. We note that the actual rate at Mobile Infirmary falls uniformly on the low side of the range of predicted mortality rates. This is particularly gratifying in light of the increased severity of illness of Medicare patients presenting for treatment at this institution.

Mobile Infirmary Medical Center, a not-for-profit hospital, has been a valuable resource to this community for more than 75 years. The 654-bed hospital has grown to be the flagship institution for the Gulf Health system which includes Rotary Rehabilitation Hospital, Washington County Infirmary (Chatom, Alabama) and George County Infirmary (Lucedale, Mississippi).

As the largest private not-for-profit hospital in the State of Alabama, the Infirmary offers primary, secondary and tertiary services to residents of Southwestern Alabama, as well as portions of Mississippi and Florida. With a medical staff of 480 physicians and 2,500 employees, the Infirmary is dedicated to being at the forefront of medical technology. The hospital's Heart Institute of the South and Cancer Institute of the South are two examples of such leadership. According to recent statistics, more than 75% of all open heart surgeries performed in this area are done at Mobile Infirmary. In fact, more surgery is performed at Mobile Infirmary than at any other hospital in the state. In 1986, the Medicare patient days were 51% of the total patient days of care rendered at the Infirmary.

Mobile Infirmary operates PRO Health Fitness and Rehabilitation Center which is unique in its approach to wellness. PRO Health is the only medically directed, comprehensive exercise facility on the Gulf Coast. The facilities at PRO Health include a 75-foot, six-lane indoor swimming pool, a multipurpose fitness room for aerobics and weight training and a padded indoor track.

MOBILE INFIRMARY MEDICAL CENTER

HCFA - October 23, 1987

Page Two

Our latest technological advances include: Magnetic Resonance Imaging, Laser Lithotripter, Sleep Disorders Center, Diabetic Resource Center and Diagnostic Ultrasound Prostate Equipment.

OUTLINE OF SERVICES OCTOBER 1, 1987

Total Licensed Beds	654
Psychiatric Beds	32
Medicine Beds	136
Surgery Beds	135
Medicine/Surgery Beds	193
Obstetrics	49
Pediatric Beds	33
CCU Beds	14
SICU, MICU, NICU	31
Rehabilitation Beds	31
Obstetrical Recovery Beds	6
Labor Beds	11
Postoperative Recovery Beds	39
Nursery	50
Operating Rooms (Surgery)	
Main Suites	13
Open Heart Suites	3
Cystoscopic Rooms	3
Laser Room	1
Endoscopic Room	1
Cast Room	1
Coronary Angiography Laboratory	
Cardiac Catheterization Rooms	2
Coronary Angioplasty	
Delivery Rooms	4
Special Services	
Emergency Evaluation Unit	
Dietary Services	
Outpatient Chemotherapy	
Renal Dialysis	
Social Work Services	
Pharmacy	
Medical Records Department	
Physical Therapy Department	
Recreational Therapy	
Pulmonary Services	
Circulation Technology Department	
Echocardiography	
Enterstomal Therapy	

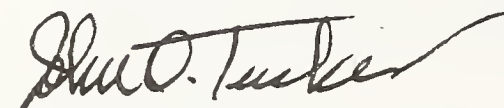
MOBILE INFIRMARY MEDICAL CENTER

HCFA - October 23, 1987

Page Three

Outpatient Surgery Rooms	4
PRO Health Department/Sports Medicine	
Diabetic Resource Center	
Sleep Disorders Center	
Audiovisual Department	
Electrodiagnostics	
Vascular Laboratory	
Gastrointestinal Laboratory	
Tumor Registry	
Radiology and Imaging	
Diagnostic X-ray	19 units
Fluoroscopy	7 units
Nuclear Medicine	
Ultra Sound	
Computerized Tomography Scanning	2 units
Magnetic Resonance Imaging	1 unit
Breast Cancer	
Radiation Therapy	
Megavoltage Therapy	4 units
Hyperthermia	1 unit
Simulators	2 units
Clinical Laboratories	
Clinical Chemistry	
Hematology	
Urinalysis	
Microbiology	
Immunohematology	
Serology	
Toxicology	
Cytology	
Histology	
Parasitology	
Radioimmunoassay	
Blood Bank	
Electron Microscopy	

Yours very truly,



JOHN O. TUCKER
President

JOT/ef

North Jackson Hospital



ROUTE 1, BOX 88 • BRIDGEPORT, ALABAMA 35740 • A.C. 205/437-2101

JOHN D. FOSTER
Administrator

COMMENTS ON THE HCFA MORTALITY DATA Hospital Provider # 010004

Dear Sir:

While we support HCFA's interest and concern about the quality of hospital care, we feel that the HCFA mortality data are not, in themselves, measures of a hospital's performance or quality. The testing of any statistical model is key to ensuring accurate results and no evidence indicates that this model has been validated as an indicator of quality.

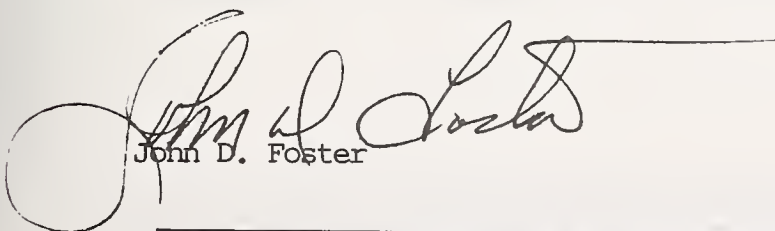
We also feel that the mortality data cannot be used as a predictor of a hospital's mortality rate. The model fails to consider a wide range of factors that have a significant impact on mortality which include the patient's general health status, the stage of patient's illness, the patient's psychological condition, family support and many other socio-economic factors.

The data used by HCFA indicates that a total of 32 Medicare patients admitted to North Jackson Hospital died within 30 days of admission. Of these, 21 died while still a patient of the hospital, while 11 died after discharge. Our own records indicate that 483 Medicare admissions occurred in 1986. Presumably the discrepancy reflects multiple admissions of individual beneficiaries to different hospitals. We have no way of verifying whether the number of Medicare patients treated at North Jackson Hospital is correct. It is impossible to determine the percentage of the 11 patients dying after discharge who were in fact alive, as information concerning death after discharge is not included in the patient's medical record.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

It is noted that the 32 mortalities listed were attributed to seven diagnostic categories out of a total of 13 categories. In these seven diagnostic categories, North Jackson Hospital's actual mortality rate falls within the midrange of predicted mortality rates.

Sincerely,



John D. Foster

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

J. Stuart Mitchell, III
Administrator



1707 21st Avenue, P.O. Box 190, Phenix City, Alabama 36868-0190 / (205) 298-7811

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Baltimore, Maryland 21207

Dear Doctor Roper:

Phenix Medical Park Hospital supports HCFA's interest and concern with the quality of hospital care. However, we feel that the HCFA mortality data are not in themselves the best measure of hospital performance or quality. We find no evidence that indicates that this statistical model has been validated as an indicator of quality.

We further do not feel that the mortality data is a good predictor of the hospital's mortality rate. It fails to consider a significant number of factors that have an impact on mortality including the stage of the patient's illness, the patient's general health status, the patient's psychological condition, family support and many other socio economic factors.

The data used by HCFA indicates that a total of 145 medicare patients admitted to Phenix Medical Park Hospital died within 30 days of admission. Of these 126 died while still a patient in the hospital, while 19 died after discharge. Our own records indicate that in excess of 2200 medicare admissions occurred in 1986 presumably the discrepancy reflects multiple admissions of individual beneficiaries to this hospital. We have no way of verifying whether the number of medicare patients treated at Phenix Medical Park Hospital is correct.

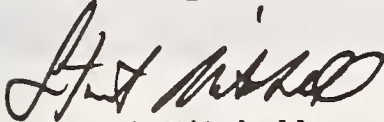
The information also has 9 incorrect dates of death. There was also 1 death with an admission and discharge date later than the one indicated on the printout.

We are attaching a corrected list for your information. Also enclosed is supplementary information that lists the dates and cause of deaths of patients that expired after discharge from the hospital. These will be indicated on the printout by an asterisk and will have the information attached to the printout.

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

Thank you for the opportunity to comment on this information prior to it being published.

Sincerely,

A handwritten signature in dark ink, appearing to read "Stuart Mitchell", written in a cursive style.

Stuart Mitchell
Administrator

/awh

Enclosures/



PROVIDENCE HOSPITAL

6801 Airport Boulevard, Post Office Box 850429, Mobile, AL 36685 205/633-1000

Comments on the HCFA Mortality Data
Providence Hospital
Mobile, Alabama
Medicare Provider Number 010090

Providence Hospital, Mobile, Alabama recognizes that consumers have a legitimate interest in obtaining useful information on the quality of hospital care. While we support the government's interest and concern about the quality of hospital care, we feel that mortality rates, by themselves, do not accurately measure a hospital's performance or quality.

Providence Hospital, a member of the Daughters' of Charity National Health System, has served Mobile and surrounding areas for 134 years. Providence has the combined the services of the region's most outstanding physicians and specialty services, including emergency services, cancer treatment, and management of pulmonary and heart conditions. The hospital's governing board, medical staff, management, and employees are committed to providing our community with quality service. Providence Hospital maintains a comprehensive quality review program. Such a program is designed to enhance patient safety, and promote appropriate utilization of resources. This is accomplished through the use of state-of-the-art technology and intervention, and through the consistent monitoring and evaluation of patient care services. In early 1987, we received a 3-year accreditation by the Joint Commission on Accreditation of Health Care Organizations.

The HCFA mortality information for Providence Hospital has been verified and corrections have been forwarded to HCFA. Our actual mortality fell within HCFA's range of predicted mortality rates. We support William L. Roper, M.D. Administrator, HCFA, in his acknowledgement that until additional statistical measures are developed to deal with complex issues such as severity of illness, we can not and do not recommend the use of the mortality information, by itself, to make judgments about the quality of care in an individual hospital or to make comparisons among hospitals. We understand that American Hospital Association and other organizations, including the Joint Commission on Accreditation of Health Care Organizations, are investigating methods of evaluating hospital quality that rely on measures other than mortality rates. We look forward to the results of those efforts.



Member of DAUGHTERS OF CHARITY NATIONAL HEALTH SYSTEM

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

Worksheet 1: Analysis of Reporting Errors

Diagnostic Category	Deaths Reported by HCFA		Deaths Verified by Hospital	
	In-hospital	Post-hospital	In-hospital	Post-hospital
CA -- Cancer	28	16	28	
CE -- Cerebrovascular Accidents	24	7	24	
GC -- Gastrointestinal Catastrophes	9	2	9	
GI -- Gastrointestinal Disease	13	1	13	
GU -- Urologic Disease	8	1	8	
GY -- Gynecologic Disease	0	0	0	
HL -- Low Risk Heart Disease	7	2	7	
HM -- Severe Chronic Heart Disease	13	3	13	
HS -- Severe Acute Heart Disease	18	0	18	
ME -- Metabolic/Electrolyte Disturbances	13	3	13	
OP -- Orthopedic Disorders	1	0	1	
PN -- Pulmonary Disease	29	12	29	
RN -- Renal Disease	7	1	7	
SE -- Sepsis	7	0	7	
TR -- Severe Trauma	2	0	2	
XX -- Ophthalmologic Disease	0	0	0	
UN -- Other Diagnoses	25	16		
Total -- All Categories	205	63		

NOTES: In the Deaths reported by HCFA, tabulate the number of deaths assigned to each diagnostic category on the individual care listing. In-hospital deaths are those patients whose date of discharge is the same as the date of death; post-hospital deaths are those patients whose date of death is after the date of discharge. Verified deaths should include those patients who are known to have died or whose status 30-days after discharge from the hospital cannot be determined. Verified deaths should also exclude patients that the hospital does not believe were ever admitted to the hospital.



October 27, 1987

William L. Roper, M.D.
Administrator
Department of Health and Human Services
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

While we support HCFA's interest and concern about the quality of hospital care, we feel that the HCFA mortality data are not, in themselves, measures of a hospital's performance or quality. The testing of any statistical model is the key to ensuring accurate results and no evidence indicates that this model has been validated as an indicator of quality.

We also feel that the mortality data cannot be used as a predictor of a hospital's mortality rate. The model fails to consider a wide range of factors and does not include measures of severity, whether the patient was transferred to the hospital from a nursing home, whether the patient was receiving treatment at home prior to admission, whether the patient had a terminal illness, or the patient's psychological state or general health.

The data used by HCFA indicates that a total of 1,333 Medicare patients were admitted to Shelby Medical Center. Of these, 104 died while still a patient of the hospital, while 37 died after discharge. SMC records indicate that 2,128 Medicare admissions occurred in 1986. Presumably, the discrepancy reflects multiple admissions of individual beneficiaries to our hospital. SMC records indicate that 107 Medicare patients died while still a patient of the hospital, while 34 were still alive at the time of discharge (Attachment I and II). It is impossible to determine the correct percentage of the patients dying after discharge as information concerning death after discharge is not included in the patient's medical record.

Sincerely,

A handwritten signature in dark ink, appearing to read "C.L. Denton", is written over the typed name.

C.L. Denton
Administrator

Enclosures

ATTACHMENT I

DEATHS REPORTED BY HCFA

DEATHS VERIFIED BY HOSPITAL

<u>Diagnostic Category</u>	<u>In-Hospital</u>	<u>Post-Hospital</u>	<u>In-Hospital</u>	<u>Post-Hospital</u>
CA -- Cancer	10	3	10	3
CE -- Cerebrovascular Accidents	9	0	9	0
GC -- Gastrointestinal Catastrophes	3	0	3	0
GI -- Gastrointestinal Disease	3	3	3	3
GU -- Urologic Disease	1	0	1	0
GY -- Gynecologic Disease	0	0	0	0
HL -- Low Risk Heart Disease	1	3	1	3
HM -- Severe Chronic Heart Disease	7	3	7	3
HS -- Severe Acute Heart Disease	20	2	20	2
ME -- Metabolic/Electrolyte Disturbances	4	7	6	5
OP -- Orthopedic Disorders	0	1	0	1
PN -- Pulmonary Disease	27	7	*28	6
RN -- Renal Disease	4	0	4	0
SE -- Sepsis	4	1	4	1
TR -- Severe Trauma	2	0	2	0
OP -- Ophthalmologic Disease	0	0	0	0
UN -- Other Diagnoses	9	7	9	7
TOTAL -- ALL CATEGORIES	104	37	107	34

ATTACHMENT II

CORRECTED DATA

<u>Patient ID Number (HIC)</u>	<u>Surname</u>	<u>Diagnostic Category</u>	<u>Age</u>	<u>Sex</u>	<u>Date of Admission</u>	<u>Date of Discharge</u>	<u>Date of Death</u>	<u>Principal Diagnosis</u>	<u>Principal Procedure</u>
[REDACTED]	[REDACTED]	ME	80	F	3/28/86	4/14/86	4/14/86	2765	4414
[REDACTED]	[REDACTED]	ME	73	M	4/11/86	4/22/86	4/22/86	2765	
[REDACTED]	[REDACTED]	PN	76	M	4/26/86	5/4/86	5/4/86	486	8954
[REDACTED]	[REDACTED]	UN	88	M	7/13/86	7/15/86	7/15/86	9721	3772
[REDACTED]	[REDACTED]	UN	73	M	7/5/86	7/13/86	After discharge	9741	8954



1127 12th Street South • Birmingham, AL 35205-5210 • (205) 930-7000

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

We have evaluated and analyzed the HCFA Medicare Mortality Rates Report which you plan to publish in December, 1987. Enclosed please find our comments which we understand will be published in their entirety and released with the report in December. We appreciate the opportunity to have our comments included in the published report.

Our analysis revealed a discrepancy in the number of post-discharge patient deaths occurring within thirty (30) days of admission. The HCFA Report has identified twenty (20) patients in this category and we have identified only eighteen (18). We have isolated two (2) patients included in the HCFA number of post-discharge deaths which were actually in-patient deaths. Copies of the Medicare bills are available upon request.

Our analysis also identified eleven (11) Medicare deaths which were not included in the HCFA Report. Copies of the Medicare bills for these patients are also available upon request.

Although we understand the motive behind releasing the mortality data, we must express our concern regarding the severe limitations of the information provided. Inadequate and inaccurate information can lead to decisions being made by or for patients which are not in the best interest of the patient. We truly hope that reliance upon this data will not result in the untimely demise of any individuals.

The hospital industry welcomes the opportunity to assist in the development of meaningful and reliable measures of quality. Please call upon us and use our expertise. Again, we appreciate being given the opportunity to include our relevant comments in the published report.

Very truly yours,

A handwritten signature in dark ink, appearing to read 'Dennis H. Descher', is written over a faint, circular embossed seal. The signature is fluid and cursive.

Dennis H. Descher
Administrator

DHD/cr

Enclosure



Medicare Provider
No. 01-0084

1212 12th Street South • Birmingham, AL 35205-5210 • (205) 930-7000

EVALUATION AND CRITIQUE
HCFA MEDICARE MORTALITY RATES

Assuring that all patients receive quality medical care is the foremost goal of South Highlands Hospital. In order to verify that this is achieved, South Highlands Hospital has developed and implemented an indepth quality assurance program. This program examines the medical care patients receive as well as the care provided by all hospital departments and personnel. As part of the quality assurance program, South Highlands Hospital reviews all patient deaths and all unexpected patient occurrences on an ongoing basis. Should a problem be identified, prompt action is taken. As part of our quality assurance activities, South Highlands Hospital has closely examined the Medicare mortality rates released by HCFA.

I. ACCURACY OF HCFA MORTALITY DATA

The data released by HCFA indicates that a total of 1,073 Medicare patients were admitted to South Highlands Hospital during 1986. This number only reflects each patient's initial admission during the year. According to our records, there were 1,736 Medicare admissions during 1986. The chronic nature of the illnesses experienced by Medicare patients requires that many patients have multiple hospital admissions during the year. Therefore, we believe that the figure which includes all Medicare admissions (1,736) is more accurate than HCFA's (1,073).

Through analysis of the data, South Highlands Hospital identified the following additional discrepancies in the data released by HCFA:

	<u>HCFA</u>	<u>SOUTH HIGHLANDS HOSPITAL</u>
Patient deaths within 30 days of admission (inpatients)	74	87
Patient deaths within 30 days of admission (post-discharge)	<u>20</u>	<u>18</u> (A)
TOTAL MEDICARE DEATHS	<u>94</u>	<u>105</u> (B)

South Highlands Hospital Comments

- A. It is impossible for South Highlands Hospital to verify the occurrence of patient deaths after discharge as this information is not normally available to the hospital. However, in our review, we identified two (2) patients which HCFA listed as post-discharge deaths which were actually inpatient deaths. In both instances, the date of death listed by HCFA was incorrect and the initial patient bill submitted by South Highlands Hospital was correct. Of the patients which HCFA documented as post-discharge deaths, eleven (11) were discharged from South Highlands Hospital with a disease in its terminal stage. At the time of their discharge, these patients no longer met the intensity of care standards required by the Medicare program for hospitalization.
- B. In addition to the deaths identified by HCFA, South Highlands Hospital was able to identify eleven (11) additional inpatient deaths which were omitted from HCFA's data. All of these patients expired within thirty (30) days of admission and had Medicare as the primary payor. In all eleven (11) instances, all information included on the initial patient bill submitted by South Highlands Hospital was correct.

A review of all patient bills submitted to Medicare by South Highlands Hospital for those patients included in HCFA's mortality statistics revealed that South Highlands Hospital had no billing errors.

"LOW RISK" DIAGNOSES

Total patients identified by HCFA - 11

South Highlands Hospital Comments

- The average age of these patients was 80.5 years.
- All patients included in this category demonstrated additional complicating conditions which, when coupled with their admitting problem, resulted in death.
- Five (5) of these patients had "Do Not Resuscitate" orders as requested by the patient and/or family.

OTHER CONDITIONS

Total patients identified by HCFA - 19

South Highlands Hospital Comments

- The average age of these patients was 80.3 years.
- Thirteen (13) of these patients demonstrated "High Risk" secondary diagnoses which were actually responsible for the patient's death as follows:

Cancer	4
Severe Chronic Heart Disease	7
Renal Failure	2
	<u>13</u>
- Six (6) of these patients had "Do Not Resuscitate" orders as requested by the patient and/or family.

II. DATA ANALYSIS

South Highlands Hospital did not exceed the "normal" range established by HCFA in any of the diagnostic categories. Analysis of the medical records of these patients revealed the following information:

"HIGH RISK" DIAGNOSES

Total patients identified by HCFA - 63

South Highlands Hospital Comments

- The following are the diagnoses which were most frequently present for these patients:

Pneumonia	12
Metastatic/Inoperable Cancer	12
Heart Attack	11
Severe Chronic Heart Disease	5
Stroke	5
Acute Renal Failure	5
Other High Risk Conditions	13
TOTAL	<u>63</u>
- The average age of these patients was 80.2 years. Only eight (8) of these patients were below the age of 70.
- Thirty-five (35) of these patients had "Do Not Resuscitate" orders as requested by the patient and/or family.
- All patients in this "high risk" group were admitted to the hospital with two (2) or more complicating conditions in addition to their primary problem.
- Of these patients, HCFA identified nine (9) as post-discharge deaths. All of these patients were discharged by their primary physician who felt that they no longer required hospital level of care. These patients also met Medicare discharge criteria.

PATIENTS OMITTED FROM DATA BY HCFA

Total patients identified - 11

- Seven (7) of these patients had "High Risk" primary diagnoses.
- Two (2) of these patients had "Low Risk" primary diagnoses. In both of these cases, the patient's failure to come to the hospital upon the onset of symptoms contributed significantly to their demise.
- Two (2) patients had "other" conditions. Both of these patients possessed additional complicating conditions which contributed to their demise.
- The average age of these patients was 77.5 years.
- All billing information initially submitted by South Highlands Hospital regarding these patients was correct. There is no obvious explanation for HCFA's omission of these patients.

FINAL COMMENTS

As previously stated, South Highlands Hospital is continually evaluating the quality of care provided to all patients regardless of method of payment. The inaccuracies we have noted in the HCFA mortality data is of grave concern to our institution. We believe that when dealing with information which potentially reflects the quality of care provided by an institution, utmost accuracy must be insured. Our re-evaluation of all Medicare patient deaths for 1986, in conjunction with our ongoing quality assurance program, has verified our belief that South Highlands Hospital is providing quality care for all of its patients.

S O U T H E A S T

A L A B A M A

M E D I C A L

C E N T E R

October 27, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Department of Health and Human Services
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Southeast Alabama Medical Center has received and reviewed HCFA's (Health Care Financing Agency of the Department of Health and Human Services) statistics related to Medicare patient mortality for 1986. We accept this report as an evaluation of a single outcome, but inadequate for assessment of quality of care for this facility. True quality judgments can be made only after reviewing and analyzing information contained in an individual patient's medical record, a continuous process here at the Medical Center with emphasis on all of the criteria for quality patient care; documentation, complications, consultations, length of stay, patient mobility, rehabilitation and discharge planning.

We recognize that SAMC has an important role in providing services to the terminally ill and in serving as a regional referral center for severely injured and for very ill patients. A higher mortality rate can be expected when we assume responsibility for patient care under those circumstances. Even so, we are extremely pleased to note that we fall well within the expected mortality range in every category.

As a regional referral center for complicated cardiovascular conditions, a radiation treatment center for tumor patients and a trauma center for treating critical injuries, we again take note of the fact that we fall within HCFA's predicted mortality rate ranges in all categories.

The results of our medical record review of HCFA's reported cases did not indicate or reveal any pattern suggesting a problem with the quality of services provided by this hospital or its staff. SAMC maintains a quality assessment program that includes monitoring and review of all patient care, but especially those who died. A patient mortality review protocol is maintained and followed at all times. The results are distributed monthly

to all medical staff department heads, the chief of staff and the physician director of professional services for comment and appropriate action. Quality assessment data is presented regularly to our Governing Board. Uniformly, our statistics, when compared to regional and national norms, indicate that SAMC's mortality rate is equal to or better than the regional and national norm.

SAMC had 16,600 admissions in 1986 of which 35%, or approximately 5,800 admissions, were on Medicare. These 5,800 admissions represented only 3,512 Medicare patients. That means that these Medicare patients had an average of 1.7 admissions each in 1986. Obviously, seven tenths of an admission is not possible, but what it does indicate, in fact, is that some of the frail and elderly had several admissions each. This 35% of admissions represents patients who utilized 46% of the hospital days and 50% of the costs of care provided by SAMC in 1986. Each of these points indicate that these Medicare patients were sicker and stayed longer than the general population. Specifically, Medicare patients stayed an average of 7.8 days per admission compared to 4.5 days per admission for the non-Medicare portion of the general population.

Several other internally generated statistics are of interest and are quite relevant to the Medicare population that we are serving. Sixteen percent of Medicare patients are under 65 and disabled with a chronic illness. Medicare patients in this hospital utilize 53% of the cardiovascular ICU days, 72% of the coronary care unit days and 58% of the intensive care unit days, again supporting the premise that because Medicare patients are sicker, they utilize a greater share of beds, days and services.

Our statistics confirm the severity of illness of Medicare patients and reveal an overall Medicare mortality rate of only 5.4% for all Medicare admissions. This compares with 0.88% for all other patients. Because HCFA's statistics consider only the last and terminal admission "outcome" and add those who died after leaving the hospital within 30 days of admission, HCFA's mortality rate of 9% does not give SAMC credit for the favorable results of admissions in which these patients were treated and improved sufficiently to be discharged from the hospital and maintained their improvement after discharge.

Further, we found HCFA's description and utilization of two diagnostic categories both misleading and objectionable. Specifically, in the "low-risk" heart disease category, we object to the inclusion of patients who had had high risk procedures such as coronary artery bypasses and patients with life threatening co-morbidities into this "low-risk" category. It suggests poor care when low-risk patients die. We anticipate that when the category is published, the "expected range" will be disregarded and that there is a higher potential for criticism of the care given. The fact of the matter is that every one of those patients carried additional "high-risk" diagnoses and co-morbidities at the time of admission. It should be recognized that they were presenting only minor prodromal symptoms on admission that were soon to crescendo into an exacerbation of their underlying pathology. Similarly, most of the deaths in

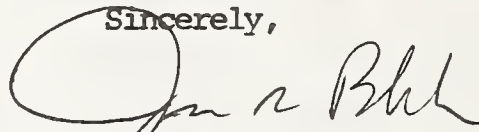
Mr. Roper
Page 3
October 27, 1987

the "metabolic disorders" category (which denote primarily Medicare patients with malnutrition and dehydration), we found to have been caused by an underlying catastrophic disease such as cancer, with malnutrition and dehydration representing only the complications of their terminal illness. Available treatment had been exhausted and prolonging unsuccessful treatment unacceptable. That circumstance illustrates only a quirk in the "principal diagnosis" coding system.

In our review of deaths after discharge from the hospital, we reaffirmed our awareness that there was no significant quality problem related to our patients' hospital or home care arrangements, but rather that these individuals were in the terminal stages of cerebrovascular disease, cardiovascular disease, end stage renal disease or cancer. The decisions that resulted in discharge from our hospital to home or nursing home care were made with the concurrence of the patient, his family and his physician. These patients were provided the assistance of social services and home nursing support to ensure continuity of care after discharge. Those patients transferred to nursing homes were sent there because their care requirements and needs exceeded the capabilities of their home care support system.

In conclusion, let us recognize the inevitability of death and acknowledge that in many instances, death is the expected outcome of some patients' circumstances and their disease characteristics. Death can occur even in the presence of the highest attainable standard of medical care. These standards are maintained by intense internal scrutiny of records and case results, by corrective action when problems surface and by the combined efforts of a concerned and caring governing board, administration, professional medical and nursing staff and employees.

Sincerely,

A handwritten signature in dark ink, appearing to read "James R. Blackmon", written over a large, loopy initial "J".

James R. Blackmon
Administrator

JRB/cbw



Bill A. Mason
President

OCTOBER 16, 1987

We have reviewed the HCFA Mortality Data sent to Springhill Memorial Hospital for the year 1986 and submit the following comments about the data:

1. The actual number of Medicare Admissions to Springhill Memorial Hospital for 1986 was 2576. The statistical report submitted indicates that 1650 Medicare patients had their last admission of 1986 to Springhill Memorial Hospital. We have no way of verifying the accuracy of this statistic.
2. HCFA Data indicates 153 patients died within 30 days of their last admission to Springhill Memorial Hospital. We were unable to verify an admission for one patient on the list, (██████████ admitted 3-2-86; died 3-21-86). (Subtract 1/HM category.)
3. Three Medicare patients died within 30 days of admission to the hospital that were not included on the list. These three deaths were inhospital deaths:
██████████ - Admitted 02-19-86; Died 03-14-86. (Add 1/TR category.)
██████████ - Admitted 03-02-86; Died 03-21-86. (Add 1/HM category.)
██████████ - Admitted 05-31-86; Died 06-02-86. (Add 1/CE category.)
4. Four patients died in the hospital which are reported as out of hospital deaths:
██████████ - Admitted 4-16-86; Died 4-17-86
██████████ - Admitted 4-13-86; Died 4-14-86
██████████ - Admitted 10-7-86; Died 10-13-86
██████████ - Admitted 12-30-85; Died 1-25-86

# Deaths/HCFA Report	- 153
# Inhospital Deaths/HCFA Report	- 128
# Out-of-Hospital Deaths/HCFA Report	- 25

# Deaths/Hospital Statistics	- 155
# Inhospital Deaths/Hospital Statistics	- 134
# Out-of-Hospital Deaths/Hospital Statistics	- 21

5. Patient ██████████ (Admitted 12-8-86; Died 4-17-86) had a primary diagnosis code listed as 162.3. The hospital's record shows a primary diagnosis code of 150.4. This discrepancy, however, did not effect the diagnostic category of this death.

COMMENTS ON THE HCFA MORTALITY DATA
 SPRINGHILL MEMORIAL HOSPITAL, MOBILE, ALABAMA
 OCTOBER 16, 1987

6. Patient [REDACTED] (Admitted 1-20-86; Died 1-21-86) had a primary diagnosis code listed as 436. The hospital's record shows a primary diagnosis code of 431. This discrepancy, however, did not effect the diagnostic category of this death.
7. Patient [REDACTED] (Admitted 03-18-86; Died 4-5-86) had a primary diagnosis code listed at 569.83. The hospital's record shows a primary diagnosis code of 551.29. The procedure code was listed at 45.61 and the hospital's records show 45.62. The change in primary diagnosis codes changes the diagnostic category from GI to GC. (Subtract 1/GI category; Add 1/GC category.)
8. Numerous procedure codes were not listed on the HCFA printout. Most of the codes not listed were diagnostic codes, however. (See attached revision of list.)
9. The Mortality Rates adjusted to reflect the above changes are as follows:

DIAGNOSTIC CATEGORY	CASES	MORTALITY RATE
ALL CAUSES	1652	9%
CA	83	19%
CE	52	27%
EY	5	0%
GC	36	25%
GI	176	6%
GU	74	3%
GY	24	0%
HL	123	7%
HM	60	30%
HS	41	29%
ME	40	25%
OP	107	1%
PN	182	12%
RN	15	13%
SE	17	24%
TR	59	5%

Bill A. Mason

 PRESIDENT, SPRINGHILL MEMORIAL HOSPITAL



St. Vincent's Hospital

2701 Ninth Court South, Birmingham, AL 35205 (205) 939-7000

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
6325 Security Blvd.
Baltimore, Maryland 21207

Re: St. Vincent's Hospital:
Provider 01-0056

Dear Dr. Roper:

St. Vincent's Hospital, Birmingham, Alabama, wishes to respond to the mortality information to be published by HCFA in December of 1987. It is important first to point out that St. Vincent's Hospital falls within the range of expected mortality for the total and all individual categories of diseases analyzed. Furthermore, in nearly 90 percent of the categories analyzed, the mortality rate was at or below the midpoint of the expected range. Therefore, although St. Vincent's is compared favorably to HCFA's expected mortality rates, the administration of the hospital has some serious concerns regarding the release and subsequent use of these data.

A first limitation is that although the data may show a relationship between the five variables chosen and mortality, there is no established significance between the five variables, the mortality rates, and the quality of care provided at specific institutions. Second, there is a limitation of the model in that it has not been validated. Further research is needed to determine if the results of the data are reliable and valid.

The third concern is that HCFA has looked at only five variables for each patient. There are other potentially significant variables which have not been included in the study, but may in fact be significant determinants of mortality. These variables include, but are not limited to, the patient's general health status, the stage of disease when first diagnosed or treated, the patient's socioeconomic status as it relates to utilization of health care resources, the patient's race, the availability of family support for the patient, and the patient's psychological condition.

The primary concern of St. Vincent's Hospital is that the data, while possibly useful in focusing quality assurance programs, has serious limitations in allowing a comparison of various hospitals with respect to quality of care provided the hospitals. Thus, once this information is released to the

William M. Roper, M.D.

October 27, 1987

Page 2

general public, regardless of the disclaimers presented with the data, interpretation of the data may lead one to believe that one hospital provides a better quality of patient care than another hospital, when, in fact, it is not statistically valid to draw such a conclusion.

St. Vincent's Hospital, therefore, would like to go on record as supporting HCFA's attempt to develop a measure of outcome and quality as a useful tool to the general public for comparing hospital services. However, the release of such data prior to establishing the reliability and validity of the analysis can be detrimental to the general public if the data are misinterpreted or interpreted without giving consideration to the limitations of the analysis.

St. Vincent's Hospital thanks you for the opportunity to respond to the data to be released by HCFA and would be happy to respond to any other questions.

Sincerely,

A handwritten signature in dark ink, appearing to read "Marc E. Sussman", followed by a horizontal line.

Marc E. Sussman
Director of Planning

MES:jo

cc: Sister Mary Frances Loftin, President
Vincent W. Donlon, Executive Vice President

Comments on the HCFA Mortality Data
Stringfellow Memorial Hospital
301 East 18th Street
Anniston, Alabama 36201

Data Verification:

The data used by HCFA indicate 757 Medicare admissions occurred in 1986. Our own records indicate 1,327 Medicare admissions during 1986. Presumably part of the discrepancy reflects multiple admissions of individual beneficiaries to different hospitals. We did not attempt to identify the difference.

The HCFA data reflected a total of 75 Medicare patients admitted to Stringfellow Memorial Hospital died within 30 days of admission. Our records indicate only 74. Of these, 64 died while still a patient of the hospital and 10 died after discharge.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in the analysis. The HCFA data are not all-inclusive, i.e. only Medicare patients are included in the analysis, which make up less than half of the total patient volume at Stringfellow Memorial Hospital. The American Hospital Association and other organizations, including the Joint Commission on the Accreditation of Hospitals, are investigating methods of evaluating hospital quality that rely on measures other than mortality rates, and we look forward to the results of these efforts.

Results of Medicare Record Review:

Stringfellow Memorial Hospital used this data to review all the records in the analysis as a follow up on our Quality Assurance Program. While there were no diagnostic categories where the mortality rate fell outside the range of predicted mortality ranges, we found several areas that indicates comment.

GI - One patient included in this category was not a patient of Stringfellow Memorial Hospital, therefore the number of cases should have been 109, with an actual mortality rate of 6%.

GU - Our analysis reflected that 45% of the deaths in this category indicated multiple high risk areas that could and possibly should have been grouped in CA or HS.

HL - The analysis reflected this patient should have been classified in category HM, thus creating a 0% mortality rate in HL and a 31% mortality rate in HM.

UN - This category (not listed) reflected 6 deaths (all other causes) with 209 admissions, or a 3% mortality rate.

Sylacauga Hospital

SCHOOL OF NURSING • NURSING HOME

October 21, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, MD 21207

Re: HCFA Mortality Data
Provider #

Dear Sirs:

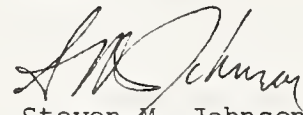
We are in receipt of the HCFA Mortality data for our hospital and wish to comment on several important issues that affect interpretation of the data. While Sylacauga Hospital does not fall outside the predicted range in any of the seventeen (17) categories, we still do not feel that the data, exclusively, is a true measure of quality.

We have reviewed each of the deaths reported for this time period. Of the 123 reported deaths in the HCFA data, 20 deaths occurred outside the hospital. Eighteen (18) of those deaths would have been expected or anticipated. Forty-eight (48) of the patients that died requested no artificial life support measures be initiated. At least 85 of the cases reviewed experienced complications involving multiple body systems. In this population death was considered a significant possibility at the time of admission in at least 98% of the cases.

It should be noted that our hospital also operates a nursing home. Nursing Homes consistently operate at 98% occupancy levels and the State Health Plan has targeted this area for at least 28 additional beds. The unavailability of nursing home beds severely compromises our ability to transfer patients who could be cared for in a non-acute setting. Higher mortality rates within the hospital setting would be expected until this problem can be resolved.

Medicare patients account for nearly one-half of all discharges at our facility. When we reviewed total deaths, regardless of payment source, our mortality rate fell to two (2) percent. One may conclude that Medicare patients are older, more acutely ill and resultingly a higher risk.

Sincerely,


Steven M. Johnson
Administrator



The University of Alabama at Birmingham
University of Alabama Hospital/Office of Administration

October 27, 1987

William L. Roper, M.D.
Administrator
Department of Health & Human Services
Health Care Financing Administration
Washington, D.C. 20201

Dear Doctor Roper:

The 1986 Medicare mortality data released by the Health Care Financing Administration (HCFA) confirms what our own longstanding regular peer review mechanisms already indicated--University of Alabama Hospital provides excellent quality of patient care. For example, in 44% of the 16 diagnostic categories HCFA studied, this hospital's "actual" mortality rate was in the lower one-fourth of the range of "predicted" mortality rates; in two categories we were below the predicted range. But there are significant problems with the HCFA data. The government used an unproven statistical model that appears to have many weaknesses. These weaknesses have produced misleading information, two of which are discussed in the following points.

1. The model produces artificially high mortality rates. In reality our 1986 mortality rate for all admissions was less than one-third of that cited by HCFA. Our 1986 mortality rate for all Medicare admissions was less than one-half of that cited. The American Hospital Association emphasized that "the mortality rate published by HCFA should not be confused with an inpatient mortality rate".

One reason for the artificially high mortality rate is the patients that were selected for the study. The sixteen categories with predicted mortality rates are based on only one-third of the most critically ill Medicare admissions. For instance, emergency transfers account for some of our most seriously ill patients. Normally, 11% of our Medicare admissions are admitted as transfers from other facilities. In the group selected by HCFA for its mortality study, 34% were transfers from other facilities. UAB's unique, certified intensive care transport jet and ground vehicles bring us patients who previously were too sick to transfer. HCFA's model, by eliminating many admissions, produced the artificially high mortality rate.

2. HCFA has stated that the model's greatest weakness is its inability to take into consideration the severity of illness (SOI) of a facility's particular mix of patients. The model does not adequately consider the type of patients treated at our inner-city, tertiary care teaching hospital. Multiple medical illnesses (complicating conditions) are one indicator of SOI. HCFA only considered eight complicating conditions (called "comorbid factors"). Patients were given a weighting factor if any one of the eight conditions were present. A great many of our Medicare patients had multiple complicating conditions which were not factored into the statistical model. More than 35% of our transfers studied by HCFA had two or more comorbid conditions. In addition, our review shows that 45% of the transfers studied by HCFA had two or more of the 16 primary diagnoses present as complications but not counted as comorbid factors. "Sepsis", for example, is one of the 16 primary conditions. Yet when it shows up as a secondary complication, it is not given consideration as a comorbid factor. One comorbid weighting factor is inadequate in a study of this nature.

HCFA reports the University of Alabama Hospital sees an inordinately large number of severely ill patients. In the most recently published Severity-of-illness Index, this hospital was ranked 12th highest of all hospitals in the nation and second among all teaching hospitals.

Despite the weaknesses in the model, the HCFA data does reflect our hospital's concrete and measurable commitment to quality of care. Every death undergoes rigorous review by the medical staff. Other measures of quality are routinely studied. The internal review mechanism has functioned to guarantee quality far beyond the consideration studied by HCFA. The quality of our care is recognized by others:

- * Referring physicians continue to send patients to us in large numbers.

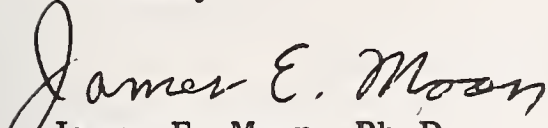
- * We are identified as the third best hospital in the nation in a national poll of physicians by former Harvard professor Herbert Dietrich.

- * We are included among the 65 (no rank given) "best hospitals in America" in the book of the same name, based on interviews with physicians, hospital officials, and others as well as a survey of the scientific and popular literature.

We believe that the public should have data available to help them form educated opinions on where to go for their health care. The Joint Commission on Accreditation of Healthcare Organizations and other accrediting agencies spend years developing and field testing valid measures of quality. We anticipate that HCFA also would feel more comfortable with a refined model in order to provide the public and the health planners more usable information on the performance of the

hospital industry. We offer to join with other hospitals and HCFA in developing such a model. We recommend that further information should not be published until a model has been developed that has demonstrated validity and reliability.

Sincerely,


James E. Moon, Ph.D.
ADMINISTRATOR *L. Jaf*

JEM/chb

UNIVERSITY OF SOUTH ALABAMA
MEDICAL CENTER

ADMINISTRATION



TELEPHONE: (205) 471-7110
2451 FILLINGIM STREET
MOBILE, ALABAMA 36617

OCTOBER 29, 1987

HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH & HUMAN SERVICES
WASHINGTON, D.C. 20201

DEAR SIRs:

THE HEALTH CARE FINANCING AGENCY HAS REPORTED 175 MEDICARE PATIENTS WHOSE LAST ADMISSION WAS TO USA MEDICAL CENTER AND WHO DIED WITHIN 30 DAYS OF THAT ADMISSION. ALL OF THESE ADMISSIONS WERE VERIFIED AS HOSPITALIZATIONS AT USAMC.

"THE STATISTICS RELEASED BY HCFA ARE WELL WITHIN THE ANTICIPATED MORTALITY RANGE," COMMENTED LEWIS D. ANDERSON, M.D., VICE PRESIDENT FOR MEDICAL AFFAIRS FOR THE UNIVERSITY OF SOUTH ALABAMA. "WE ARE NOT ON THE HIGH SIDE, STATISTICALLY, AND DATA APPEAR ON THE LOW END OF THE SCALE ON MANY," HE CONTINUED. HCFA'S MORTALITY STATISTICS BY DIAGNOSTIC CATEGORY ARE BASED ON THE PRINCIPLE DIAGNOSIS ASSIGNED TO THE PATIENT UPON THE LAST REPORTED ADMISSION TO THE HOSPITAL.

"WE QUESTION WHETHER THE MORTALITY RATES ARE COMPLETELY ACCURATE SINCE THE ACTUAL CAUSE OF DEATH OFTEN VARIES FROM THE ADMITTING DIAGNOSIS," ADDED ANDERSON. FOR EXAMPLE, ONCE A PATIENT IS ADMITTED WITH A DIAGNOSIS OF CANCER, FUTURE ADMISSIONS CANNOT BE FOR CANCER, ACCORDING TO MEDICARE GUIDELINES. ON SUBSEQUENT HOSPITALIZATIONS, THE ADMITTING DIAGNOSIS IS BASED ON SYMPTOMATOLOGY, SUCH AS PNEUMONIA, INSTEAD OF THE UNDERLYING DIAGNOSIS. THEREFORE, WHEN THE PATIENT ACTUALLY SUCCOMBS, THE CAUSE OF DEATH MAY BE CODED AS PNEUMONIA WHICH WAS IN REALITY, A COMPLICATION OF THE CANCER.

THE UNIVERSITY OF SOUTH ALABAMA MEDICAL CENTER IS A REGIONAL REFERRAL CENTER, A LEVEL I TRAUMA CENTER AND A TEACHING HOSPITAL. AS SUCH, ITS HIGHEST CENSUS OCCURS IN THE SEVEN SPECIALTY INTENSIVE CARE UNITS: MEDICAL, SURGICAL, NEURO-TRAUMA, PEDIATRIC, BURN, NEO-NATAL, AND CARDIAC INTENSIVE CARE.

CHARACTERISTICALLY, PATIENTS ARE ADMITTED TO USAMC IN SEVERE, COMPLEX AND/OR ADVANCED CONDITIONS. IN ORDER TO INSURE QUALITY AND APPROPRIATENESS OF CARE, USAMC CONSTANTLY MONITORS AND EVALUATES MORTALITY DATA AND A VAST ARRAY OF QUALITY INDICATORS AS WELL.

SINCERELY,

Lewis D. Anderson by Gail C. Lee

LEWIS D. ANDERSON, M.D./GAIL C. LEE, ASSISTANT ADMINISTRATOR



DEPARTMENT OF THE ARMY
US ARMY MEDICAL DEPARTMENT ACTIVITY
FORT MCCLELLAN, ALABAMA 36205-5083

October 16, 1987

REPLY TO
ATTENTION OF

Patient Administration
Division

William L. Roper, M.D.
Health Care Financing Administration
Health Standard & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Sir:

Reference your attached letter.

This facility does not classify patients as Medicare patients. As a Uniformed Military Treatment Facility, we treat eligible active duty members, retirees, and their family members. If you could tell us exactly the information you are seeking by age category, we would be willing to provide it.

Sincerely,

A handwritten signature in cursive script, reading "John E. Ball", is positioned above the typed name.

John E. Ball
Captain, U.S. Army
Chief, Patient Administration
Division



DEPARTMENT OF THE ARMY
HEADQUARTERS UNITED STATES ARMY AEROMEDICAL CENTER
FORT RUCKER, ALABAMA 36362-5333

REPLY TO
ATTENTION OF:

October 16, 1987

Deputy Commander for
Clinical Services

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Hospital mortality information for 1986 has been reviewed by this facility. Comments concerning this information are attached.

Sincerely,

A handwritten signature in black ink, appearing to read "Thomas I. Clements", is written over a horizontal line.

THOMAS I. CLEMENTS
COL, MC

Deputy Commander for Clinical Services

Comments on the HCFA Mortality Data
Lyster US Army Community Hospital, Fort Rucker, Alabama
HOSPITAL ID # 01016F

Data Verification

The data used by HCFA indicate that a total of 1 Medicare patient admitted to Lyster US Army Community Hospital died within 30 days of admission. Our own records indicate that 4 Medicare patients died within 30 days of admission during 1986. Patients are identified below, A-D. Presumably, the discrepancy reflects the only civilian Medicare patient admitted to this facility to die within 30 days as the other 3 were all military retirees.

Interpretive Remarks

This facility did not receive from HCFA information concerning the number of Medicare beneficiaries treated, this facility's mortality rate or the range of predicted mortality rate by diagnostic category. Therefore, no conclusions can be drawn without this information. Our records reveal 170 Medicare beneficiaries were discharged during 1986.

Unique Services Resulting in Higher than Average Mortality

Non applicable.

Results of Preliminary Medical Record Review

Patient A. Patient had acute Myocardial Infarction before arrival at this facility. Unsuccessful CPR. Death was not attributable to any care provided by this hospital. (Case identified by HCFA.)

Patient B. Death was the expected outcome at the time this cancer patient was admitted. Admission for terminal care.

Patient C. Death was the expected outcome at the time this cancer patient was admitted. Admission for terminal care.

Patient D. Death was not expected at the time this patient with cerebrovascular disease was admitted, but was a significant possibility.

ATTACHMENT 5

Hospital ID # 01016F

Worksheet 1: Analysis of Reporting Errors

Diagnostic Category	Deaths Reported by HCFA		Deaths Verified by Hospital*	
	In-hospital	Post-hospital	In-hospital	Post-hospital
CA -- Cancer			2	
CE -- Cerebrovascular Accidents			1	
GC -- Gastrointestinal Catastrophes				
GI -- Gastrointestinal Disease				
GU -- Urologic Disease				
GY -- Gynecologic Disease				
HL -- Low Risk Heart Disease				
HM -- Severe Chronic Heart Disease				
HS -- Severe Acute Heart Disease	1		1	
ME -- Metabolic/Electrolyte Disturbances				
OR -- Orthopedic Disorders				
PN -- Pulmonary Disease				
RN -- Renal Disease				
SE -- Sepsis				
TR -- Severe Trauma				
OP -- Ophthalmologic Disease				
UN -- Other Diagnoses				
Total -- All Categories	1		4	

NOTES: In the Deaths reported by HCFA, tabulate the number of deaths assigned to each diagnostic category on the individual care listing. In-hospital deaths are those patients whose date of discharge is the same as the date of death; post-hospital deaths are those patients whose date of death is after the date of discharge. Verified deaths should include those patients who are known to have died or whose status 30-days after discharge from the hospital cannot be determined. Verified deaths should also exclude patients that the hospital does not believe were ever admitted to the hospital.



VAUGHAN
Regional Medical Center, Inc.

VAUGHAN REGIONAL MEDICAL CENTER
COMMENTS ON HCFA MORTALITY DATA

MEDICARE PROVIDER NUMBER: 01-0121

While we support HCFA's interest and concern about the quality of hospital care, we feel that the HCFA mortality data is not, in itself, a measure of a hospital's performance or quality. No evidence indicates that this statistical model ensures accurate results or is an indicator of quality. The model fails to consider a wide range of factors that have a significant impact on mortality such as patient's general health status, the stage of a patient's illness, the patient's psychological condition, family support and many other socioeconomic factors.

The data used by HCFA indicates a total of 663 Medicare patients having their last admission of 1986 at the Vaughan Regional Medical Center. Of that number, HCFA indicates that 62 patients died within 30 days of this last hospitalization period. This results in HCFA's overall mortality rate for this hospital of 10% (the HCFA predicted range is 8 - 16%).

Our own records indicate 1121 Medicare discharges in 1986 with 49 deaths (an overall Medicare rate of 4.4%). Our overall mortality rate for all patients in 1986 is less than 1.2%.

HCFA's number of admissions is based on a patient's last 1986 admission to any hospital. This explains part of the discrepancy found in the above numbers as we have no way of verifying patient admissions to other hospitals. The number of deaths is based on deaths within 30 days of the admission. Again, we cannot verify the number of patient deaths after discharge (information about events after discharge is not included in the patient's medical record). These deaths may have been unrelated to the condition that was under treatment during hospitalization.

In each of the diagnostic categories outlined by HCFA, the VRMC actual mortality rate falls well within the HCFA predicted ranges. We appeared to have lower performance (though well within the predicted range) in the Severe Acute Heart Disease Category. The predicted range is listed as 21 - 70% and according to HCFA, the VRMC actual Medicare range is 64%. This category includes patients with acute myocardial infarction as well as other disease conditions such as ruptured abdominal aneurysm. The patients who died included patients with complicating disease conditions such as cancer. Again, the patient's general health status or the stage of the patient's illness is not considered in the HCFA data. In this same Severe Acute Heart Disease category for all patients our data indicates a mortality rate of 23%.

In general these statistical analyses of mortality rates are not meaningful as quality judgments can only be made after reviewing information in a patient's medical record. The quality of Hospital and Medical Staff performance is internally monitored on an ongoing basis to ensure high quality care.

Administrator: Frank Gannon

Alaska

Medicare Hospital Mortality Information

HOSPITALS		High Risk Diagnostic Categories																							
		Overall			Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
Name/Location	Comment/Reference																								
ALASKA NATIVE MEDICAL CENT ANCHORAGE AK 99510	AK-3 *	218	9	6-16	30	10	10-42	3	33	3-83	8	0	2-55	7	14	6-66	4	50	9-84				14	36	4-45
BARROW HOSPITAL BARROW AK 99723	AK-4 *	7	0	1-57	.	.		1	0	0-97	.	.		.	.		.	.		.	.	2	0	0-91	
BARTLETT MEMORIAL HOSPITAL JUNEAU AK 99801	AK-5 *	197	10	6-16	9	11	4-56	7	29	5-64	12	8	2-46	12	17	5-50	8	50	12-72	4	25	2-75	18	11	4-38
CENTRAL PENINSULA GENERAL SOLOOTNA AK 99669	AK-6	113	12	7-20	2	0	1-89	3	67	4-84	2	0	0-92	6	33	3-65	8	25	9-66	1	0	0-97	16	13	7-47
CORDOVA COMMUNITY HOSPITAL CORDOVA AK 99574	AK-7 *	20	20	5-38	2	100	1-89	1	0	1-97	.	.		2	0	1-89	3	33	5-86	.	.		1	0	0-98
FAIRBANKS MEMORIAL HOSPITA FAIRBANKS AK 99701	AK-8 *	405	9	6-15	20	15	10-48	14	29	9-53	12	8	6-52	20	15	8-44	7	43	10-71	10	20	5-55	32	16	6-33
FAITH HOSPITAL GLENALLEN AK 99588	AK-9 *	9	0	1-50	.	.		.	.		.	.		.	.		.	.		.	.	4	0	1-74	
HUMANA HOSPITAL ALASKA ANCHORAGE AK 99501	AK-10	294	7	7-17	18	28	13-54	15	33	12-56	6	17	3-65	12	17	5-50	7	29	11-73	6	0	1-64	32	6	7-35
KANAKANAK HOSPITAL OILLINGHAM AK 99576	AK-11 *	22	9	4-34	1	100	2-98	.	.		1	0	0-99	2	0	3-91	2	50	2-89	.	.		1	0	0-99
KETCHIKAN GENERAL HOSPITAL KETCHIKAN AK 99901	AK-12	155	10	7-19	7	57	8-70	8	25	6-61	9	11	6-60	6	33	7-71	6	17	8-74	2	0	1-89	13	0	4-46
KODIAK ISLAND HOSPITAL KODIAK AK 99615	AK-13 *	62	5	5-23	4	50	3-76	1	100	0-97	3	0	2-81	5	0	4-72	2	0	5-93				6	0	4-66
MOUNT EDGE-CUMBE HOSPITAL MOUNT EDGE-CUMBE AK 99835	AK-14 *	19	5	1-31	1	0	0-99	1	0	1-97	1	0	0-100	1	100	0-98	.	.		.	.		.	.	
NORTON SOUND REGIONAL HOSP NOME, ALASKA 99672	AK-15 *	25	12	4-32	.	.		.	.		2	0	0-95	2	0	2-90	1	0	2-98				5	20	1-68
PETERSBURG GENERAL HOSPITA PETERSBURG AK 99833	AK-16 *	19	37	4-38	4	100	1-74	1	100	1-97	.	.		2	0	1-89	1	100	2-98	1	0	0-100	4	25	1-74
PHS ALASKA NATIVE SVC HOSP KOTZEBUE AK 99752	AK-17 *	11	9	2-47	.	.		.	.		.	.		.	.		.	.		.	.		2	0	0-90
PROVIDENCE HOSPITAL ANCHORAGE AK 99504	AK-18	901	12	8-16	79	24	16-38	20	15	11-49	21	19	4-38	51	20	13-36	26	58	22-59	21	14	5-40	79	11	9-28
SEWARD GENERAL HOSPITAL SEWARD AK 99664	AK-19 *	46	11	5-26	2	100	2-90	2	50	1-89	2	0	1-89	3	0	1-81				1	0	0-100	10	10	7-58
SITKA COMMUNITY HOSPITAL SITKA AK 99835	AK-20	56	9	4-22	1	0	0-99	1	0	0-97	2	0	0-96	1	0	0-98	3	33	7-88	3	0	1-81	5	20	3-70
SOUTH PENINSULA HOSPITAL HOMER AK 99603	AK-21 *	88	5	5-19	6	50	7-72	1	0	1-97	2	50	2-90	5	0	3-69	3	0	6-87				6	0	2-63
VALOEZ COMMUNITY HOSPITAL VALOEZ AK 99686	AK-22 *	7	43	7-67	1	0	3-99	1	100	1-97	1	0	0-100	1	0	0-97	1	100	1-97	.	.		.	.	
VALLEY HOSPITAL PALMER AK 99645	AK-23	156	9	9-21	9	22	10-66	2	50	3-91	4	25	1-74	12	17	5-49	9	33	12-69	8	25	6-63	26	4	7-37
WRANGELL GENERAL HOSPITAL WRANGELL AK 99929	AK-24 *	17	18	1-35	.	.		1	0	0-97	1	100	0-98	1	0	0-98	.	.		1	0	0-97	1	0	0-97
YUKON KUSKOKWIM DELTA REG' BETHEL AK 99559	AK-25 *	38	11	5-29	1	100	2-98	1	0	0-97	1	100	0-99	3	33	2-81	2	0	2-90				11	9	3-48

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

AK-2

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
ALASKA NATIVE MEDICAL CENT ANCHORAGE AK 99510	.	.	.	1	0	1-97	13	0	1-40	7	0	0-100	24	8	0-25	19	0	0-39	5	0	0-100	8	13	0-59	22	0	0-37
BARROW HOSPITAL BARROW AK 99723	.	.	.	.	.	.	.	.	.	.	.	.	1	0	0-100	.	.	.	.	.	.	.	.	.	.	.	.
BARTLETT MEMORIAL HOSPITAL JUNEAU AK 99801	3	33	0-85	1	0	0-97	10	0	0-51	3	0	0-100	23	0	1-26	3	0	0-100	1	0	0-100	11	0	0-47	8	0	0-98
CENTRAL PENINSULA GENERAL SOLDOTNA AK 99669	2	0	0-94	1	0	1-97	5	20	1-68	.	.	.	5	0	0-76	1	0	0-100	2	0	0-100	5	0	0-79	5	0	0-100
CORDOVA COMMUNITY HOSPITAL CORDOVA AK 99574	1	0	0-97	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	1	100	0-100	1	0	0-100	1	0	0-100
FAIRBANKS MEMORIAL HOSPITA FAIRBANKS AK 99701	3	33	0-85	5	20	9-80	18	17	1-33	15	7	0-68	25	4	1-24	11	0	0-52	2	0	0-100	24	0	1-25	31	0	0-24
FAITH HOSPITAL GLENALLEN AK 99588	.	.	.	1	0	0-97	.	.	.	.	.	.	.	.	.	.	.	.	1	0	0-100	.	.	.	.	.	.
HUMANA HOSPITAL ALASKA ANCHORAGE AK 99501	6	0	3-67	2	50	3-91	7	0	0-67	8	0	0-100	23	0	1-26	11	0	0-54	2	0	0-100	23	0	1-26	23	4	0-40
KANAKANAK HOSPITAL OILLINGHAM AK 99576	.	.	.	.	.	.	1	0	0-99	.	.	.	1	0	0-100	2	0	0-100	.	.	.	1	0	0-100	.	.	.
KETCHIKAN GENERAL HOSPITAL KETCHIKAN AK 99901	1	0	0-100	2	0	1-89	9	11	2-52	.	.	.	14	0	0-40	4	0	0-79	.	.	.	8	0	0-57	8	0	0-97
KODIAK ISLAND HOSPITAL KODIAK AK 99615	.	.	.	.	.	.	1	0	0-100	.	.	.	4	0	0-90	.	.	.	.	.	.	5	0	0-81	4	0	0-97
MOUNT EDGECUMBE HOSPITAL MOUNT EDGECUMBE AK 99835	.	.	.	.	.	.	.	.	.	2	0	0-100	3	0	0-100	1	0	0-100	.	.	.	.	.	.	1	0	0-100
NORTON SOUND REGIONAL HOSP NOME, ALASKA 99672	2	50	1-90	.	.	.	.	.	.	1	0	0-100	.	.	.	.	.	1	0	0-100	1	0	0-100	1	0	0-100	
PETERSBURG GENERAL HOSPITA PETERSBURG AK 99833	.	.	.	.	.	.	.	.	.	.	.	.	1	0	0-100	.	.	.	.	.	.	.	.	.	.	.	.
PHS ALASKA NATIVE SVC HOSP KOTZEBUE AK 99752	.	.	.	1	0	1-97	.	.	.	.	.	.	2	0	0-95	1	100	1-97	.	.	.	1	0	0-100	.	.	.
PROVIDENCE HOSPITAL ANCHORAGE AK 99504	13	15	4-52	5	0	11-82	23	13	2-29	2	0	0-100	76	4	2-15	29	0	1-24	10	0	0-61	100	10	2-11	64	0	0-12
SEWARD GENERAL HOSPITAL SEWARD AK 99664	1	0	0-100	.	.	.	.	.	.	1	0	0-100	1	0	0-100	.	.	.	.	.	.	3	0	0-94	2	0	0-100
SITKA COMMUNITY HOSPITAL SITKA AK 99835	.	.	.	.	.	.	4	25	0-78	.	.	.	6	0	0-79	.	.	.	1	0	0-100	7	0	0-62	3	0	0-100
SOUTH PENINSULA HOSPITAL HOMER AK 99603	.	.	.	.	.	.	.	.	.	1	0	0-100	8	0	0-55	3	0	0-99	2	0	0-100	16	0	0-35	5	0	0-93
VALDEZ COMMUNITY HOSPITAL VALDEZ AK 99686	.	.	.	.	.	.	.	.	.	.	.	.	1	100	1-97	.	.	.	.	.	.	.	.	.	.	.	.
VALLEY HOSPITAL PALMER AK 99645	4	25	5-80	1	0	1-97	4	0	0-77	.	.	.	22	0	0-27	2	0	0-90	.	.	.	12	0	0-47	3	0	0-98
WRANGELL GENERAL HOSPITAL WRANGELL AK 99929	.	.	.	.	.	.	.	.	.	.	.	.	1	100	0-100	.	.	.	.	.	.	.	.	.	1	0	0-100
YUKON KUSKOKWIM DELTA REG' BETHEL AK 99559	.	.	.	.	.	.	1	0	0-100	.	.	.	1	0	0-100	1	0	0-98	.	.	.	.	.	.	1	0	0-100

*Written Comments Not Submitted.



Central Peninsula General Hospital

Operated by Lutheran Hospitals and Homes Society

250 HOSPITAL PLACE • SOLDOTNA, ALASKA 99669

(907) 262-4404

October 23, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Medicare Provider number: 020024

Dear Dr. Roper:

The first item to discuss is that, though it is true that all of the Medicare beneficiaries listed were patients in our hospital in 1986, and they all expired, there are a few corrections we would like to make in your data. One patient [REDACTED] was admitted to our hospital, and was then transferred to another acute care facility where he subsequently expired. In three cases [REDACTED], the Alaska Professional Review Organization changed the principal diagnosis after review of the medical record. We concurred with these changes, but apparently the revised diagnoses were not forwarded to HFCA (two of these cases involved patients whose principal diagnosis was changed to terminal cancer.) One other correction involves a patient [REDACTED] who passed away in our hospital, but was shown in your records to have been discharged, expiring six days later.

We would like to take this opportunity to assure you that our hospital places strong emphasis on delivering quality patient care. We have a systematic approach to quality assurance whereby, using occurrence screening and monitoring of critical indicators in patient care areas, potential quality concerns are identified and acted on promptly. Our medical staff is strongly supportive of our Quality Assurance program, is active in peer review, and shares the hospital's commitment to providing quality care.

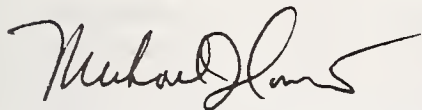
Though the actual mortality rates for Medicare beneficiaries in our hospital are within the predicted ranges, we would like to offer a few comments regarding the validity of this information. Because of the limited characteristics included in the statistical model, we do not feel that one can use this information to judge the quality of care delivered by our hospital. However, we do have systems in place which are used to

identify concerns and by which we are able to determine that quality care is being provided. As part of our identification process, mortality reviews are done to monitor quality and appropriateness of care. Those reviews done for 1986 deaths did not identify any cases where patient demise was attributable to inadequate or insufficient medical or hospital care.

Our small rural hospital of 62 bed capacity with an average daily census of 23 provides very small numbers with which to conduct a statistical analysis. The small figures that must be worked with make it difficult to produce meaningful, significant data. What is significant is that each patient who is admitted to our hospital is monitored for adverse events, their comments regarding their care are solicited and reviewed, and prompt attention is given to any opportunity for improvement. We are secure in the knowledge that we are able to identify quality concerns and that our Quality Assurance program provides the mechanism through which to resolve them.

Thank you for the opportunity to comment on the mortality information before its publication.

Sincerely,

A handwritten signature in dark ink, appearing to read "Michael J. Lockwood". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Michael J. Lockwood
Hospital Administrator

2801 DeBar Road
PO Box 142889
Anchorage, Alaska
99514 3162
Telephone 907 276-1131

George G. Schneider
Executive Director

Humana Hospital Alaska

October 27, 1987

William L. Roper, M.D.
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
6325 Security Boulevard
Baltimore, MD 21207

Dear Dr. Roper:

Thank you for the opportunity to comment on the hospital specific mortality data provided to us late last month. Humana Hospital - Alaska supports the Health Care Financing Administration's desire to educate those interested in Medicare quality issues. We recognize this program is early in its development stages. While its measurements are preliminary and rough, it is clearly an example of the type of quality measurements to come.

This information is helpful in our hospital's ongoing quality assurance program that includes regular and complete review of all admissions which result in patient mortality, regular morbidity and mortality reviews, quality assurance, utilization review, as well as complete outside review by the Joint Commission on Accreditation of Healthcare Organizations and other outside review organizations.

Since these raw numbers reflect deaths which occurred in only a limited segment of a hospital's patient population (the elderly) and are not adjusted for severity of illness or other factors which may affect patient outcome, they must be considered in that context and should serve as only one of numerous indicators used to review the quality of services provided at a hospital. While this statistical data is useful in this format for professional evaluation, it is not beneficial for consumer use. As a result, consumers should be informed as to the limited scope of these numbers, and be cautioned about drawing any conclusions from the data about the quality of a particular hospital's services.

As in all deaths occurring in hospitals, a complete internal review is necessary to determine the appropriateness of the outcome and may provide information to physicians and other medical providers about improvements which can be made in treating future patients. Thus, the use of raw mortality statistics is helpful to professionals in identifying patient trends and treatment outcomes. Additionally, they may assist health care consumers in understanding the extensive quality control systems in place in hospitals.

Our hospital's staff has reviewed the data. Since some deaths occurred outside the hospital, we have been unable to completely validate this data. Generally, we have found it to be consistent with our hospital records. Unfortunately, in most cases the number of patients in a particular category is too small to provide a valid statistical analysis. In addition, the predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner, it would be inappropriate to consider them acceptable or unacceptable "standards."

I hope this information will be helpful in attempting to refine the collection and reporting of Medicare hospital data. In addition, our hospital will do everything possible to assist our community in understanding how this data can best be used to improve health care services.

Sincerely,

George G. Schneider / P.S.
George G. Schneider

Ketchikan General Hospital

3100 TONGASS AVE.
KETCHIKAN, ALASKA 99901

October 26, 1987

Medicare Provider # 020004

William L. Roper, M. D., Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Mr. Roper:

We have reviewed your report of the mortality data for our hospital. We found:

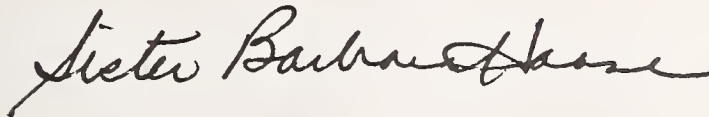
1. We actually admitted 214 Medicare patients during 1986 instead of the 155 which your mortality methodology identified.
2. Six (6) of the fifteen (15) deaths happened outside the hospital:
 - a. Cancer patient wanted to die at home and we supported the patient and family in their decision.
 - b. At least three of the patients were transferred to long term care facilities of which there are two in our community.
 - c. One patient was admitted to our hospital only because her home city was fogged in, grounding all planes. She was being transferred back from Seattle.
 - d. Five of the patients were diagnosed with death as the expected outcome.
 - e. Four patients were over the age of 88 with death as the expected outcome by the physician.

I have a concern that death among our elderly citizens is not necessarily an all-encompassing quality assurance measure. I have a strong conviction that if we could qualify some of our Medicare hospital patients for a period of Medicare skilled nursing care,

William Roper, M.D., Administrator
October 26, 1987

that the quality of life for them could be significantly improved. The availability of Home Health services could be a strong support to family members who try so hard to maintain their elderly at home.

Sincerely,

A handwritten signature in cursive script, reading "Sister Barbara Haase". The signature is written in dark ink and is positioned above the typed name.

Sister Barbara Haase
Administrator

ek

PROVIDENCE HOSPITAL
3200 PROVIDENCE DRIVE
P.O. BOX 190004
ANCHORAGE, ALASKA 99519-0004
PHONE (907) 562-2271



October 26, 1987

Health Care Financing Administration
Department of Health and Human Services
P.O. Box 26676
Baltimore, Maryland 21201

ATTN: HSQ-148-GNC

Gentlemen:

In response to the invitation to review and comment on the Medicare mortality report by the Health Care Financing Administration (HCFA), we have several comments.

Providence Hospital is the medical referral center in Alaska and cares for critically ill and injured patients referred to us from throughout the state. Providence has the only open-heart surgery program; the only comprehensive cancer treatment program; the only dedicated thermal unit caring for burns and cold injuries; and provides care for complex medical and surgical care problems of patients from throughout the state. Therefore we care for many of the Medicare patients.

We have found errors in the data HCFA provided us from which you made your calculations. It appears that HCFA significantly under reported the total Medicare discharges and at the same time have included patients of whom we have no record. Further, we can not verify the methodologies you used to analyse the data, therefore we can not verify the conclusions.

Even with these concerns we note that the overall mortality rate and rate for each diagnostic category are well within ranges you have predicted. Given the concentration of Medicare patients with complex health problems served at Providence Hospital, we are pleased your data presents so favorable a conclusion. With the corrections we have identified, the calculated mortality rates would decrease even further.

Sincerely,



Richard Towell
Associate Administrator

SISTERS OF PROVIDENCE INSTITUTIONS—ALASKA: PROVIDENCE HOSPITAL, ANCHORAGE—OUR LADY OF COMPASSION CARE CENTER, ANCHORAGE—WASHINGTON: PROVIDENCE CENTRAL MEMORIAL HOSPITAL, TOPPENISH—PROVIDENCE HOSPITAL, EVERETT—PROVIDENCE MEDICAL CENTER, SEATTLE—THE DePAUL RETIREMENT RESIDENCE AND MOUNT ST VINCENT NURSING CENTER, SEATTLE—ST. ELIZABETH MEDICAL CENTER, YAKIMA—ST. PETER HOSPITAL, OLYMPIA—ST. JOSEPH HOSPITAL, ABERDEEN—ST. HELEN HOSPITAL, CHEHALIS—OREGON: PROVIDENCE CHILD CENTER, PORTLAND—PROVIDENCE MEDICAL CENTER, PORTLAND—ST. VINCENT HOSPITAL AND MEDICAL CENTER, PORTLAND—SEASIDE GENERAL HOSPITAL, SEASIDE—PROVIDENCE HOSPITAL, MEDFORD—PROVIDENCE MILWAUKIE HOSPITAL, MILWAUKIE—CALIFORNIA: PROVIDENCE HOSPITAL, OAKLAND—PROVIDENCE HIGH SCHOOL, BURBANK—SAINT JOSEPH MEDICAL CENTER, BURBANK.

SITKA COMMUNITY HOSPITAL

209 MOLLER AVENUE • SITKA, ALASKA 99835 • (907) 747-3241

October 12, 1987

William L. Roper, M.D.
Administrator
Department of Health & Human Services
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for your letter of 21 September 1987 concerning mortality information.

The hardiness of our basic population, the natural culling process forcing those not adaptable to our area back to the lower forty-eight, and other factors--including a quality medical staff, an excellent hospital staff, and a well-equipped and maintained hospital--have all made our statistics look good this year.

Our hospital is small by almost anyone's statistical yardstick, but it is a good hospital. However, one death in a category that is numerically only one would make us appear 100% fatal. That the patient was appropriately admitted for care/stabilization but was terminal does not color that cold 100% number, regardless of the "sophisticated statistical techniques" used.

If there is concern about the quality of care in an institution, evaluate that care during the normal--or even extraordinary--evaluations that are held under the auspices of Medicare, State licensure, Joint Commission, or the host of other regulatory review organizations. Surely the information garnered by such statistical reports, such as the one furnished by your office, can be used more meaningfully, if indeed it must be used.

Incidental statistics can do much harm to worthy institutions when selectively applied, such as in the case of one death for one patient in one category equaling 100% mortality. Though a minor error, the same point can be made for/against your reports sent to our organization. There was a date error on the referenced letter. Indeed, a minor point, yet that makes 100% of the reports sent here erroneous for this topic. Is that a meaningful error--we

Dr. William Roper
October 12, 1987
Page 2

would agree the answer is no. Selectively applied, however, it does contain the potential for discreditation of the reports and discreditation of the credibility of the organization's reputation for accuracy.

I would request that the program be rethought. If statistics indicate a hospital or other institution provides faulty care, have appropriate people look into the hospital. Don't damage an otherwise worthy institution with statistical quirks. As we may be of assistance, please feel free to contact us.

Sincerely,


Ed Malewski
Administrator

EM/nc

cc: AHA
HAA
Sen. Stevens
Sen. Murkowski
Rep. Young



515 E. Dahlia
P.O. Box 1687
Palmer, AK 99645

October 9, 1987 907-745-4813

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Washington, DC 20201

Re: Comments on the HCFA Mortality
Data 020006

Dear Dr. Roper:

Your decision to gather and publish data and mortality rates of the aged for hospitals assumes that aged mortality may be of some significance in reviewing practice patterns for quality. We suggest instead that aged mortality is a normal expected outcome of living and, therefore, is more significant to quality of life than quality of health care.

A review of maternal/child mortality may be more useful to improving this practice of medicine, especially since these outcomes are undesirable and should not be normally expected.

The use of data involving mortality after discharge from a hospital wherein the hospital no longer exercises control is definitely misleading when attributed to the hospital. Many individuals leave a hospital to die with dignity at home or in Hospice, or are returned to nursing homes because this level of care may be more appropriate. Still others leave the hospital and die from trauma not directly related to their hospital care. Yet, somehow, you believe this speaks to the hospital practice patterns!

In the reverse situation our institution, as a suburban provider, often admits patients for "terminal care" who are transferred here from our urban medical centers to "die near home." They are admitted here an average of 3-4 days prior to death. This type of study may make pre-terminal patients "hot potatoes" and potentially deny them access to local resources of terminal care.

The socioeconomics of our community and the resultant impact on individual health do not lend well to comparisons "in general" with the entire nation.

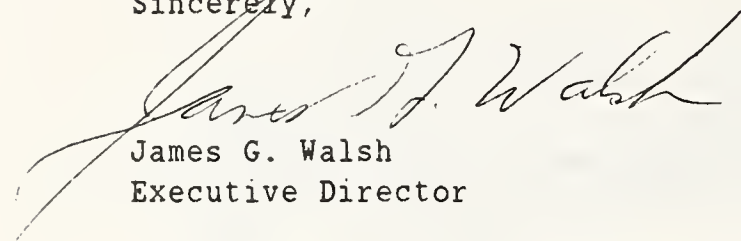
By your admission, your statistical model does not address the severity of the individual's illness and is an incomplete measure of the practice patterns.

In our area where the aged population comprises only 2.09% of the community and this same percentage carries over to those who use our service, mortality of the aged, which is expected, is not reflected in overall mortality.

Letter - William L. Roper, M.D.
October 9, 1987
Page 2

It would appear that your agency either cannot promote true quality of health care indicators or chooses to irresponsibly promote incomplete and misleading indicators of practice pattern quality. We find it disappointing that Federal tax dollars are squandered thusly.

Sincerely,



James G. Walsh
Executive Director

JGW/kw

cc: Honorable Frank Murkowski
United States Senate
709 Hart Bldg.
Washington, DC 20510

Honorable Ted Stevens
United States Senate
522 Hart Bldg.
Washington, DC 20510

Honorable Donald Young
2331 Rayburn Bldg.
Washington, DC 20515

Honorable Edward Kennedy
315 Senate Russell Office Bldg.
Constitution and Delaware Avenues, NE
Washington, DC 20510
(Chairman-Committee on Health and Human Services)

Arizona

Medicare Hospital Mortality Information

		High Risk Diagnostic Categories																							
		Overall			Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
HOSPITALS		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
Name/Location	Comment/Reference																								
BAPTIST MEDICAL CTR-SCOTT'S SCOTTSDALE AZ 85257	AZ-7	162	9	5-16	11	27	5-54	3	0	4-84	1	0	0-100	6	0	3-65	1	0	1-97	6	0	1-64	15	20	5-45
BENSON HOSP BENSON AZ 85602	AZ-8 *	141	14	8-21	6	50	3-65	4	25	4-77	2	0	0-91	21	29	10-47	4	0	7-82	6	67	7-72	23	17	8-42
BULLHEAD COMMUNITY HOSP BULLHEAD CITY AZ 86430	AZ-9 *	647	12	8-15	44	23	12-39	5	60	8-78	20	20	6-42	31	23	12-42	18	56	20-63	15	47	10-55	86	15	10-28
CASA GRANDE REGIONAL MED C CASA GRANDE AZ 85222	AZ-10	701	10	8-16	28	43	11-44	20	25	12-51	18	11	4-41	43	23	13-39	36	33	19-50	4	0	5-79	80	14	12-31
CHANDLER REGIONAL HOSPITAL CHANDLER AZ 85224	AZ-11 *	894	10	7-15	49	29	12-38	30	20	13-44	28	18	5-34	56	18	11-33	26	50	23-60	23	9	6-40	91	14	9-26
CHINLE COMPREHENSIVE CARE CHINLE AZ 86503	AZ-12 *	161	14	8-20	4	25	7-82	4	25	3-76	4	0	1-74	10	30	7-59	4	50	8-83	10	0	2-50	18	33	8-46
COMMUNITY HOSP MEDICAL CEN PHOENIX AZ 85015	AZ-13 *	276	5	5-14	12	25	8-57	6	33	5-68	5	20	2-69	13	15	7-51	1	0	1-97	6	17	1-64	25	0	5-35
COMMUNITY HOSPITAL ASSOCIA WICKENBURG AZ 85358	AZ-14	251	15	9-19	13	77	14-63	6	33	6-70	14	14	4-46	7	14	4-62	19	32	21-63	11	18	2-49	32	16	5-31
COPPER QUEEN COMMUNITY HOS BISBEE AZ 85603	AZ-15	256	14	9-20	14	21	12-58	8	13	7-64	3	33	1-81	18	28	9-47	7	29	17-80	7	29	3-62	39	15	9-35
DESERT SAMARITAN HOSP HL MESA AZ 85202	AZ-16	3584	11	8-14	354	25	19-33	109	25	17-35	66	6	7-28	118	25	14-30	118	37	26-45	56	18	10-35	281	18	12-24
EL DORADO MEDICAL CENTER TUCSON AZ 85712	AZ-17	1768	9	6-13	127	31	16-35	25	40	15-50	36	6	6-33	61	34	13-34	59	31	24-49	18	17	5-43	106	19	11-28
FLAGSTAFF HOSP MED CENTER FLAGSTAFF AZ 86002	AZ-18	767	8	7-14	66	18	15-39	36	28	16-45	25	4	4-34	21	10	8-42	21	33	15-54	6	17	2-64	79	16	9-27
GILA GENERAL HOSPITAL GLOBE AZ 85501	AZ-19 *	216	13	6-17	11	27	8-58	13	38	10-56	4	25	0-75	8	38	5-60	7	29	11-73	8	13	2-56	27	15	6-35
GOOD SAMARITAN MED CTR PHOENIX AZ 85006	AZ-20	4910	10	8-14	466	23	18-31	112	21	20-38	91	12	10-29	164	24	17-31	136	29	27-45	99	15	8-28	358	17	14-25
HAVASU REGIONAL HOSPITAL LAKE HAVASU CITY AZ 86403	AZ-21 *	748	9	6-14	47	23	14-41	13	23	12-59	17	29	7-46	22	14	9-44	19	47	15-55	11	9	2-49	73	21	9-29
HOLY CROSS HOSP HEALTH CT NOGALES AZ 85621	AZ-22 *	205	10	7-17	13	46	11-59	3	67	4-84	10	10	4-52	9	11	4-55	2	0	7-96	8	25	2-56	22	9	9-44
HUMANA DESERT VALLEY HOSP PHOENIX AZ 85032	AZ-23	1151	12	8-15	98	21	15-35	41	34	16-43	25	24	7-39	53	25	14-37	35	37	24-56	21	19	5-40	116	12	9-25
HUMANA HOSPITAL PHOENIX PHOENIX AZ 85016	AZ-24	1580	12	9-16	139	22	17-36	65	20	20-43	63	17	10-32	70	21	13-33	55	36	26-52	24	21	7-41	134	22	13-29
JOHN C LINCOLN HOSP AND HL PHOENIX AZ 85020	AZ-25	1903	12	8-15	131	27	16-34	64	33	17-39	34	9	5-32	83	23	15-34	54	39	24-51	47	11	9-35	205	19	13-26
KENNECOTT HOSPITAL KEARNY AZ 85237	AZ-26	66	6	4-21	1	100	2-99	1	0	0-97	1	0	0-100	2	0	0-90	1	0	2-98	2	0	2-89	17	12	3-38
KINO COMMUNITY HOSP TUCSON AZ 85713	AZ-27	649	17	11-19	22	32	9-45	18	33	15-56	25	36	8-41	28	25	10-42	22	64	22-61	16	6	3-42	112	30	15-32
LEWIS R PYLE MEMORIAL HOSP PAYSON AZ 85541	AZ-28	485	8	6-14	16	44	10-53	15	7	10-53	14	21	4-45	17	29	8-48	10	50	15-70	8	50	3-58	59	5	8-29
MARCUS J LAWRENCE MEMORIAL COTTONWOOD AZ 86326	AZ-29	1328	10	8-15	90	22	16-37	30	23	14-46	30	17	5-34	60	15	12-33	49	31	24-52	32	16	7-37	152	12	11-26
MARICOPA CO GEN HOSP PHOENIX AZ 85008	AZ-30	1817	19	9-16	77	35	18-40	70	39	19-41	67	33	9-30	73	19	14-33	65	55	28-52	53	26	7-32	259	41	15-28
MARYVALE SAMARITAN HOSPITA PHOENIX AZ 85031	AZ-31 *	1583	12	8-15	112	33	18-38	43	30	17-44	26	8	4-34	73	22	13-32	90	43	26-47	34	15	7-36	152	17	11-26
MESA GENERAL HOSP MEDICAL MESA AZ 85201	AZ-32 *	980	9	7-14	46	28	13-40	28	18	13-46	30	10	6-35	49	31	12-36	21	33	20-60	17	6	3-40	104	9	9-25

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

AZ-2

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
BAPTIST MEDICAL CTR-SCOTTS SCOTTSDALE AZ 85257	.	.		2	100	3-91	8	0	2-54	1	0	0-100	26	4	0-24	5	0	0-76	.	.		12	0	0-42	7	0	0-99
BENSON HOSP BENSON AZ 85602	1	0	0-98	1	0	0-97	8	0	1-54	.	.		15	0	0-37	6	0	0-64	2	0	0-100	11	9	0-44	6	17	0-98
BULLHEAD COMMUNITY HOSP BULLHEAD CITY AZ 86430	8	25	5-63	4	50	8-83	2	0	0-97	.	.		97	3	1-11	77	5	1-14	6	0	0-100	58	5	1-14	7	0	0-98
CASA GRANDE REGIONAL MEO C CASA GRANDE AZ 85222	15	7	6-52	6	17	14-81	21	10	1-30	1	0	0-100	84	4	2-12	33	3	0-23	8	0	0-100	57	2	1-14	46	4	0-16
CHANDLER REGIONAL HOSPITAL CHANDLER AZ 85224	9	11	4-59	5	40	8-78	25	12	4-32	3	0	0-100	110	4	1-10	47	9	1-19	11	0	0-100	86	3	2-12	39	3	0-20
CHINLE COMPREHENSIVE CARE CHINLE AZ 86503	5	0	1-71	2	100	5-93	2	0	0-92	.	.		9	0	0-53	11	18	1-44	.	.		6	0	0-69	.	.	
COMMUNITY HOSP MEDICAL CEN PHOENIX AZ 85015	4	0	1-77	1	0	2-98	3	0	0-85	2	0	0-100	41	7	1-18	15	0	0-37	2	0	0-100	24	8	1-26	25	0	0-39
COMMUNITY HOSPITAL ASSOCIA WICKENBURG AZ 85358	2	0	2-90	5	80	11-82	.	.		.	.		39	3	1-18	1	0	0-98	1	0	0-100	32	3	1-20	4	0	0-100
COPPER QUEEN COMMUNITY HOS BISBEE AZ 85603	5	60	7-78	3	33	7-89	5	0	1-67	.	.		33	15	1-21	4	0	0-84	5	0	0-100	23	9	1-26	5	0	0-99
DESERT SAMARITAN HOSP HL MESA AZ 85202	22	9	6-46	26	23	19-57	83	8	4-18	9	0	0-98	391	4	3-8	147	5	1-11	58	2	0-23	534	7	2-6	256	1	0-4
EL DORADO MEDICAL CENTER TUCSON AZ 85712	5	20	3-72	8	25	12-72	19	16	1-32	49	0	0-46	180	4	2-10	84	4	1-13	24	0	0-95	278	4	2-8	169	1	0-5
FLAGSTAFF HOSP MED CENTER FLAGSTAFF AZ 86002	7	43	7-70	7	29	13-77	19	5	1-31	1	0	0-100	73	3	1-13	40	0	0-24	10	0	0-100	54	4	1-14	75	0	0-11
GILA GENERAL HOSPITAL GLOBE AZ 85501	1	0	0-98	.	.		8	0	0-57	.	.		22	14	1-27	6	0	0-64	1	0	0-100	20	5	0-29	7	0	0-95
GOOD SAMARITAN MED CTR PHOENIX AZ 85006	89	17	7-35	24	38	21-60	83	10	3-17	6	0	0-100	399	6	3-8	200	3	1-10	75	0	0-40	640	5	3-7	386	1	0-4
HAVASU REGIONAL HOSPITAL LAKE HAVASU CITY AZ 86403	7	14	6-68	4	25	3-76	42	5	2-21	.	.		81	4	1-12	94	2	1-13	24	0	0-93	44	0	1-16	47	0	0-15
HDLY CROSS HOSP HEALTH CT NOGALES AZ 85621	5	20	1-71	1	100	2-99	6	0	1-62	.	.		31	0	1-21	15	0	0-58	5	0	0-100	15	13	0-35	5	0	0-99
HUMANA DESERT VALLEY HOSP PHOENIX AZ 85032	4	0	3-77	16	44	17-63	31	3	3-26	2	0	0-100	133	4	2-11	85	4	1-13	8	0	0-100	89	4	2-11	70	0	0-10
HUMANA HOSPITAL PHOENIX PHOENIX AZ 85016	9	33	6-62	9	22	14-71	65	11	4-21	11	0	0-99	207	5	2-10	43	12	1-19	23	0	0-93	88	7	2-12	147	1	0-6
JOHN C LINCOLN HOSP AND HL PHOENIX AZ 85020	16	0	4-48	12	17	11-62	110	12	3-15	16	0	0-99	225	7	3-10	98	1	1-13	17	0	0-85	116	2	2-11	109	2	0-7
KENNECOTT HOSPITAL KEARNY AZ 85237	1	0	0-98	1	0	2-98	.	.		.	.		11	0	0-46	4	0	0-80	.	.		6	0	0-74	1	0	0-100
KINO COMMUNITY HOSP TUCSON AZ 85713	9	22	9-66	8	38	11-70	48	10	4-24	3	0	0-100	39	13	2-22	30	7	3-27	1	0	0-100	36	8	1-20	12	0	0-67
LEWIS R PYLE MEMORIAL HOSP PAYSON AZ 85541	4	0	1-76	6	67	8-74	6	0	1-62	1	0	0-100	96	2	1-11	21	0	0-31	7	0	0-100	45	7	1-16	11	0	0-90
MARCUS J LAWRENCE MEMORIAL COTTONWOOD AZ 86326	4	75	4-79	7	29	11-74	61	16	3-19	2	0	0-100	187	4	3-10	79	1	1-14	18	0	0-97	85	5	1-11	126	1	0-7
MARICOPA CO GEN HOSP PHDENIX AZ 85008	20	30	5-46	33	36	18-53	84	13	3-16	6	0	0-100	118	13	2-12	72	14	2-16	6	0	0-100	84	2	2-13	44	2	0-17
MARYVALE SAMARITAN HOSPITA PHDENIX AZ 85031	13	23	4-52	6	33	9-74	46	4	3-22	5	0	0-100	183	5	2-10	64	0	1-15	13	0	0-89	125	9	2-10	83	0	0-9
MESA GENERAL HOSP MEDICAL MESA AZ 85201	6	0	1-67	11	0	13-65	23	13	2-30	1	0	0-100	123	2	1-10	56	9	1-16	12	0	0-100	74	4	2-13	96	1	0-8

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		High Risk Diagnostic Categories																							
		Overall			Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
Name/Location	Comment/Reference																								
MESA LUTHERAN HOSP MESA AZ 85201	AZ-33	3678	10	8-15	352	26	21-35	112	23	19-37	76	14	8-28	136	24	15-30	125	30	29-48	65	9	8-30	246	19	12-25
MIAMI-INSPIRATION HOSPITAL MIAMI AZ 85539	AZ-34 *	297	8	5-14	25	32	10-45	7	29	6-67	4	0	0-78	7	0	3-61	5	0	11-81	5	0	0-72	20	10	7-42
MOHAVE GEN HOSP KINGMAN AZ 86401	AZ-35	1004	12	7-14	41	24	11-39	43	33	16-43	17	24	7-46	54	24	11-34	32	50	21-54	16	19	8-51	120	17	10-26
MT GRAHAM COMMUNITY HOSP SAFFORD AZ 85546	AZ-36	351	14	9-18	14	43	11-57	17	29	10-51	13	31	3-46	23	17	8-41	19	37	17-58	5	0	0-70	51	14	10-32
NAVAPACHE HOSP LAKESIDE AZ 85929	AZ-37	348	14	8-17	14	29	8-52	8	63	9-67	8	13	3-58	15	13	5-45	21	57	19-59	7	0	2-59	25	16	8-40
NORTHERN COCHISE COMM HOSP WILCOX AZ 85643	AZ-38	130	15	5-18	1	100	0-97	6	83	6-70				8	50	5-61	5	40	9-79	3	0	0-83	20	30	5-40
NORTHLANO MEDICAL CTR HOLBROOK, AZ 86025	AZ-39 *	94	12	5-20	2	100	0-92	2	0	1-89	1	0	0-97	7	14	3-61	6	83	9-74	4	0	1-74	12	8	7-54
NORTHWEST HOSP TUCSON AZ 85741	AZ-40	1154	11	8-15	82	29	14-35	29	28	15-47	25	4	4-33	45	22	13-38	39	38	26-57	31	23	13-45	124	19	12-28
PAGE HOSP PAGE AZ 86040	AZ-41	70	10	5-21	1	0	0-99	1	0	0-97	3	33	0-83	3	33	3-83	6	0	10-75	3	0	0-87	10	10	2-49
PARKER COMMUNITY HOSPITAL PARKER AZ 85344	AZ-42	392	10	7-16	16	38	11-54	4	25	4-77	13	8	3-45	19	32	8-44	18	33	22-65	5	0	5-74	43	14	7-31
PARKER PHS INDIAN HOSPITAL PARKER AZ 85344	AZ-43 *	31	3	2-25	1	0	0-97							1	0	2-98	1	0	1-97	3	0	0-83	1	0	0-99
PHOENIX BAPTIST HOSP AND M PHOENIX AZ 85015	AZ-44	2913	10	7-13	242	17	15-30	69	26	18-40	54	11	6-27	135	22	14-29	101	41	28-49	60	22	9-32	214	22	11-24
PHOENIX GEN HOSP PHOENIX AZ 85036	AZ-45	1344	10	7-14	76	24	15-37	27	30	14-48	25	28	8-40	54	31	13-35	32	53	21-54	25	12	7-40	98	22	10-28
PHOENIX MEMORIAL HOSPITAL PHOENIX, AZ 85007	AZ-46 *	994	11	8-15	65	26	14-37	29	21	15-47	24	17	9-43	74	11	13-33	26	54	22-59	24	13	5-37	96	18	11-28
PHS INOIAN HOSP KEAMS CANYON AZ 86034	AZ-47 *	69	4	8-26	1	100	0-98	3	0	5-85	2	0	1-89	1	0	0-97	1	0	2-98	1	0	0-98	24	8	9-42
PHS INDIAN HOSPITAL FORT DEFIANCE AZ 86504	AZ-48 *	145	8	7-19	5	60	10-80	1	0	0-97	3	0	1-81	12	17	6-51	1	0	0-97	3	0	0-84	28	18	9-39
PHS INDIAN HOSPITAL SACATON AZ 85247	AZ-49 *	37	16	4-26	1	100	3-99				1	0	0-97							2	0	1-89	3	67	1-81
PHS INDIAN HOSPITAL SAN CARLOS AZ 85550	AZ-50 *	26	12	3-29				2	0	1-89				1	0	0-98	1	0	1-97	1	100	0-97	1	0	0-98
PHS INOIAN HOSPITAL SELLS AZ 85634	AZ-51	56	7	5-24				2	0	3-91	2	0	0-94	2	0	3-91				2	0	0-89	8	38	5-60
PHS INDIAN HOSPITAL TUBA CITY AZ 86045	AZ-52 *	182	10	8-19	6	33	6-70	3	33	6-87	4	0	2-75	4	0	2-75	3	33	6-87	4	0	1-74	43	14	12-38
PHS INDIAN HOSPITAL WHITE RIVER AZ 85941	AZ-53	47	4	6-27	4	50	7-82				1	0	0-99	3	0	1-81							14	0	4-44
PHS INOIAN MEDICAL CENTER PHOENIX AZ 85016	AZ-54	167	11	4-15	7	43	5-64	3	0	2-82	4	25	6-80	8	25	5-60	5	60	10-80	1	0	0-99	13	8	2-42
PINAL GENERAL HOSP FLORENCE AZ 85232	AZ-55 *	243	14	6-15	6	33	5-68	8	50	6-62	6	17	2-64	4	0	3-75	3	33	4-85	11	18	3-51	31	26	7-35
SAGE MEMORIAL HOSPITAL GANADO AZ 86505	AZ-56 *	68	4	5-22	2	50	2-90	1	0	0-97	1	0	0-100	8	13	4-58	1	100	0-97				19	0	5-40
SCOTTSDALE MEM HOSP SCOTTSDALE AZ 85251	AZ-57	3643	10	8-14	297	22	18-33	99	24	19-38	68	10	10-31	165	30	17-31	150	32	29-46	54	17	7-31	272	12	13-25
SCOTTSDALE MEM HOSP - NORT SCOTTSDALE AZ 85260	AZ-58	542	10	6-14	40	40	14-43	19	32	11-49	13	15	2-44	17	24	8-47	12	42	16-67	9	11	3-55	51	8	7-28

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

AZ-4

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
MESA LUTHERAN HDSP MESA AZ 85201	20	20	7-48	31	32	18-53	96	6	5-18	29	7	0-47	469	4	3-8	160	1	1-11	39	0	0-68	321	4	3-8	255	1	0-4
MIAMI-INSPIRATION HDSPITAL MIAMI AZ 85539	.	.	.	6	33	8-73	9	0	0-52	.	.	.	50	6	1-16	21	0	0-32	6	0	0-100	45	7	1-16	36	3	0-25
MDHAVE GEN HDSP KINGMAN AZ 86401	8	25	3-60	.	.	.	18	22	1-32	2	0	0-100	149	6	2-9	61	5	1-15	9	0	0-100	139	4	2-10	63	3	0-11
MT GRAHAM COMMUNITY HDSP SAFFORD AZ 85546	1	100	1-97	6	67	10-76	14	0	1-38	.	.	.	38	3	1-18	4	0	0-83	3	0	0-100	31	6	1-21	14	0	0-76
NAVAPACHE HDSP LAKESIDE AZ 85929	10	10	4-58	7	57	10-73	12	0	1-42	.	.	.	44	7	1-17	2	0	0-93	3	0	0-100	39	3	1-17	23	0	0-42
NDRTHERN COCHISE CDMM HDSP WILLCOX AZ 85643	3	0	1-82	.	.	.	3	0	0-92	.	.	.	20	0	0-30	2	50	0-97	1	0	0-100	13	0	0-39	7	0	0-95
NRTHLAND MEDICAL CTR HOLBROOK, AZ 86025	2	0	0-94	.	.	.	.	.	.	.	.	.	7	0	0-73	2	0	0-100	1	0	0-100	16	6	0-34	2	0	0-100
NORTHWEST HDSP TUCSDN AZ 85741	6	17	11-79	4	0	6-81	31	10	3-26	2	0	0-100	163	3	2-10	75	3	0-14	1	0	0-100	65	12	1-13	80	0	0-9
PAGE HDSP PAGE AZ 86040	1	100	3-99	.	.	.	2	0	0-94	1	0	0-100	7	0	0-74	1	0	0-99	1	0	0-100	8	0	0-58	9	0	0-96
PARKER COMMUNITY HDSPITAL PARKER AZ 85344	5	60	6-77	.	.	.	4	0	0-77	.	.	.	54	4	1-15	16	0	2-36	1	0	0-100	49	6	2-17	11	0	0-73
PARKER PHS INDIAN HDSPITAL PARKER AZ 85344	.	.	.	.	.	.	.	.	.	.	.	.	2	50	0-93	2	0	0-93	.	.	.	2	0	0-96	.	.	.
PHDENIX BAPTIST HDSP AND M PHOENIX AZ 85015	27	15	6-44	20	45	18-60	85	7	4-18	38	0	0-46	329	3	2-7	141	2	1-11	43	0	0-66	276	6	3-8	242	2	0-5
PHDENIX GEN HDSP PHDENIX AZ 85036	11	9	4-55	16	13	14-60	22	14	3-32	2	0	0-100	141	2	3-12	79	0	1-14	21	0	0-75	176	5	2-9	92	0	0-8
PHDENIX MEMORIAL HDSPITAL PHDENIX, AZ 85007	10	40	7-61	9	0	12-69	21	5	1-29	6	0	0-100	89	2	1-12	33	0	1-22	5	0	0-100	69	1	1-12	67	0	0-11
PHS INDIAN HOSP KEAMS CANYDN AZ 86034	3	0	1-83	1	0	0-97	.	.	.	.	.	.	1	0	0-100	1	0	0-100	.	.	.	4	0	0-77	2	0	0-100
PHS INDIAN HOSPITAL FDRT DEFIANCE AZ 86504	.	.	.	2	50	3-92	1	0	0-98	.	.	.	17	0	1-33	9	0	1-50	2	0	0-100	8	0	0-60	6	0	0-98
PHS INDIAN HOSPITAL SACATON AZ 85247	1	0	1-98	1	0	0-97	.	.	.	1	0	0-100	1	100	0-97	.	.	.	.	.	.	.	.	.	.	.	.
PHS INDIAN HOSPITAL SAN CARLDS AZ 85550	1	0	0-100	1	100	1-97	.	.	.	.	.	.	6	0	0-63	1	0	0-100	.	.	.	2	0	0-100	.	.	.
PHS INDIAN HDSPITAL SELLS AZ 85634	1	0	0-99	1	0	0-97	.	.	.	.	.	.	5	0	0-84	1	0	0-100	.	.	.	1	0	0-100	1	0	0-100
PHS INDIAN HOSPITAL TUBA CITY AZ 86045	7	14	3-64	1	100	2-98	.	.	.	8	0	0-100	17	0	0-33	15	0	0-37	1	0	0-100	4	0	0-85	6	0	0-98
PHS INDIAN HDSPITAL WHITE RIVER AZ 85941	2	0	2-90	1	0	2-98	1	0	0-98	.	.	.	2	0	0-91	2	0	0-94	.	.	.	1	0	0-97	2	0	0-100
PHS INDIAN MEDICAL CENTER PHDENIX AZ 85016	2	100	4-92	1	0	1-97	3	0	1-81	50	0	0-39	9	11	0-63	12	0	0-45	4	0	0-100	3	33	0-85	5	20	0-100
PINAL GENERAL HDSP FLDRENCE AZ 85232	5	60	5-75	2	0	1-89	9	22	1-50	.	.	.	29	3	0-22	4	0	0-80	3	0	0-100	14	0	0-38	3	0	0-100
SAGE MEMORIAL HDSPITAL GANADO AZ 86505	1	0	0-100	1	0	1-97	.	.	.	.	.	.	3	0	0-86	3	0	0-83	.	.	.	4	0	0-91	2	0	0-100
SCOTTSDALE MEM HDSP SCOTTSDALE AZ 85251	36	25	12-48	24	25	20-60	124	10	4-15	12	0	0-100	375	4	2-8	109	1	1-12	40	0	0-66	460	3	3-7	293	1	0-4
SCOTTSDALE MEM HDSP - NDRT SCOTTSDALE AZ 85260	7	14	5-67	3	33	6-87	16	13	2-36	.	.	.	56	5	1-14	30	0	0-29	.	.	.	44	0	1-16	48	0	0-18

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		High Risk Diagnostic Categories																									
		Overall			Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease				
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent		
Name/ Location	Comment/ Reference	SIERRA VISTA COMM HOSP SIERRA VISTA AZ 85635	AZ-59 *	603	9	7-14	31	23	10-41	15	40	10-53	21	10	4-38	20	15	8-44	15	20	16-62	13	23	4-48	52	19	10-32
SOUTHEAST ARIZONA MEDICAL OOUGLAS AZ 85607	AZ-60	303	12	9-18	9	33	5-59	5	40	4-71	13	8	2-43	16	13	6-45	11	36	20-73	11	27	2-48	39	18	16-45		
ST JOSEPHS HOSP TUCSON AZ 85711	AZ-61	2882	11	8-14	211	20	15-31	61	46	19-43	54	15	8-30	107	18	16-33	100	40	29-49	48	19	7-32	237	24	14-27		
ST JOSEPHS HOSP MED CTR PHOENIX AZ 85013	AZ-62	4802	9	7-14	494	25	19-33	164	20	20-35	81	10	11-32	162	17	17-31	117	35	28-47	70	11	8-30	266	15	12-24		
ST LUKE'S HOSP PHOENIX AZ 85006	AZ-63	1786	6	4-11	50	20	14-40	32	25	13-44	19	26	5-41	46	17	12-36	49	24	22-49	14	14	3-45	79	10	11-30		
ST LUKES BEHAVIORIAL HLTH PHOENIX AZ 85006	AZ-64 *	237	1	1-10	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.			
ST MARY'S HOSP HEALTH CTR TUCSON AZ 85745	AZ-65	4026	10	8-15	281	22	17-32	105	29	20-38	68	18	12-34	162	20	17-31	166	33	29-46	70	14	10-33	285	15	14-26		
TEMPE COMM HOSP TEMPE AZ 85281	AZ-66 *	516	13	8-17	33	36	14-45	22	27	12-48	7	29	3-61	34	24	12-41	20	50	19-59	16	38	5-45	41	17	6-30		
THUNDERBIRD SAMARITAN HOSP GLENDALE AZ 85306	AZ-67	1622	12	8-15	134	37	17-36	50	34	16-41	24	8	4-36	60	15	14-36	63	51	26-51	28	11	7-39	147	21	14-29		
TUCSON GENERAL HOSPITAL TUCSON AZ 85719	AZ-68 *	1712	9	8-14	114	21	15-35	61	11	18-42	24	21	4-35	81	22	14-32	60	37	26-52	39	23	9-37	120	16	12-28		
TUCSON MEDICAL CENTER TUCSON AZ 85733	AZ-69	4661	10	8-15	406	26	19-34	162	23	20-35	121	13	9-26	172	25	17-30	210	31	29-44	62	16	7-30	299	16	14-26		
UNIVERSITY MEDICAL CENTER TUCSON AZ 85724	AZ-70	1626	10	8-15	161	19	17-35	25	28	14-49	23	13	6-39	66	18	14-35	68	28	27-51	20	35	7-45	109	20	12-28		
VA HOSP TUCSON AZ 85713	AZ-71 *	7	0	0-59	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.			
VALLEY LUTHERAN HOSP MESA AZ 85206	AZ-72	2582	12	8-15	194	20	15-31	72	33	16-37	61	13	5-26	141	21	15-30	127	47	28-47	55	18	9-34	306	18	12-24		
VALLEY VIEW COMMUNITY HOSP YOUNGTOWN AZ 85363	AZ-73	1204	10	7-14	65	28	15-38	30	23	16-48	30	3	5-34	53	23	13-36	31	42	21-55	16	25	8-50	100	28	12-29		
WALTER O BOSWELL MEM HOSP SUN CITY AZ 85351	AZ-74	6953	12	9-15	751	26	19-32	239	23	22-36	205	15	9-24	266	27	18-30	283	47	32-46	109	19	10-30	545	18	14-24		
WHITE MOUNTAIN COMMUNITIES SPRINGVILLE AZ 85938	AZ-75 *	126	6	7-20	4	0	6-80	7	57	8-69	1	0	1-97	8	0	3-56	2	0	3-91	2	0	0-91	21	5	6-40		
WINSLOW MEM HOSP WINSLOW AZ 86047	AZ-76 *	165	19	10-22	6	83	9-75	4	25	8-83	3	67	1-81	3	33	1-81	12	50	16-67	6	0	3-65	38	21	9-35		
YAVAPAI COMMUNITY HOSPITAL PRESCOTT AZ 86301	AZ-77	1530	11	8-15	116	28	16-36	44	23	15-42	37	24	7-34	82	17	13-32	59	49	27-52	15	7	4-45	186	16	13-26		
YUMA REGIONAL MEICAL CENT YUMA AZ 85364	AZ-78 *	2462	12	8-15	164	23	18-35	99	32	18-36	51	18	7-30	99	33	14-31	105	42	27-47	42	21	7-34	286	15	13-25		

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

AZ-6

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
SIERRA VISTA COMM HOSP SIERRA VISTA AZ 85635	8	25	8-68	8	25	9-68	13	0	1-40	6	0	0-99	78	3	1-12	37	5	1-20	5	0	0-100	59	3	2-15	55	4	0-13
SOUTHEAST ARIZONA MEDICAL DOUGLAS AZ 85607	1	0	3-100	9	44	14-71	13	23	1-40	.	.	.	60	3	1-14	7	0	1-57	7	0	0-100	11	9	0-46	15	0	0-60
ST JOSEPHS HOSP TUCSON AZ 85711	21	38	11-54	20	30	16-57	94	7	3-16	116	1	0-8	337	5	2-8	114	3	1-12	43	0	0-27	175	6	2-9	222	0	0-5
ST JOSEPHS HOSP MEO CTR PHOENIX AZ 85013	28	21	8-46	19	47	19-63	124	7	3-14	59	0	0-25	435	4	3-8	163	2	1-11	62	0	0-55	455	6	2-7	450	0	0-3
ST LUKE'S HOSP PHOENIX AZ 85006	2	0	0-90	3	33	11-92	29	7	3-27	167	0	0-5	114	5	2-12	22	0	1-28	9	0	0-100	298	7	3-8	414	1	0-4
ST LUKES BEHAVIORIAL HLTH PHOENIX AZ 85006	.	.	.	.	.	.	.	.	.	.	.	.	1	0	0-100	.	.	.	.	.	.	.	.	.	18	0	0-53
ST MARY'S HOSP HEALTH CTR TUCSON AZ 85745	34	18	9-44	53	34	25-54	115	9	4-17	13	0	0-87	422	4	3-9	185	2	1-10	16	0	0-95	386	8	3-8	379	1	0-4
TEMPE COMM HOSP TEMPE AZ 85281	3	67	5-87	7	29	10-72	19	0	1-32	1	0	0-100	75	4	2-14	12	0	0-43	1	0	0-100	39	3	1-18	30	0	0-24
THUNDERBIRO SAMARITAN HOSP GLENOALE AZ 85306	12	8	5-55	10	30	13-69	55	9	3-20	3	0	0-100	193	5	2-9	85	6	1-14	27	0	0-95	148	2	2-9	82	2	0-9
TUCSON GENERAL HOSPITAL TUCSON AZ 85719	10	10	5-59	11	27	14-68	31	6	2-25	3	0	0-100	205	3	2-9	92	2	1-13	18	0	0-91	160	3	2-9	114	1	0-7
TUCSON MEDICAL CENTER TUCSON AZ 85733	35	20	8-42	32	34	18-53	123	6	4-15	9	0	0-95	481	5	3-8	257	2	1-10	61	0	0-25	399	5	3-7	421	1	0-4
UNIVERSITY MEDICAL CENTER TUCSON AZ 85724	20	20	6-48	12	58	17-69	42	14	4-25	9	0	0-100	103	7	3-14	84	2	1-14	4	0	0-100	176	6	3-10	148	3	0-6
VA HOSP TUCSON AZ 85713	7	0	0-71	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
VALLEY LUTHERAN HOSP MESA AZ 85206	19	11	4-45	29	24	16-52	86	12	4-18	.	.	.	384	3	2-8	143	4	1-11	35	0	0-36	243	2	2-8	181	2	0-5
VALLEY VIEW COMMUNITY HOSP YOUNGTOWN AZ 85363	6	17	2-66	8	63	11-70	41	15	2-22	1	0	0-100	117	5	2-12	71	4	1-15	5	0	0-100	47	0	1-16	141	1	0-6
WALTER O BOSWELL MEM HOSP SUN CITY AZ 85351	36	31	14-50	59	20	23-51	225	7	5-15	10	0	0-100	775	5	3-8	462	3	1-9	33	0	0-65	707	4	3-7	551	1	0-3
WHITE MOUNTAIN COMMUNITIES SPRINGVILLE AZ 85938	2	0	0-90	2	50	3-91	1	0	0-99	.	.	.	13	0	0-43	.	.	.	1	0	0-100	6	0	0-74	2	0	0-100
WINSLOW MEM HOSP WINSLOW AZ 86047	1	0	0-100	4	75	9-84	4	0	0-79	1	100	0-100	17	0	1-32	2	50	1-89	.	.	.	13	15	2-40	1	0	0-100
YAVAPAI COMMUNITY HOSPITAL PRESCOTT AZ 86301	5	20	3-72	7	14	8-70	31	10	2-25	5	0	0-99	203	2	2-9	56	2	1-16	25	0	0-93	114	5	2-11	78	1	0-9
YUMA REGIONAL MEDICAL CENT YUMA AZ 85364	19	11	7-49	15	13	15-63	56	5	2-19	10	0	0-100	224	7	2-9	130	4	1-11	13	0	0-100	256	3	2-7	142	1	0-6

*Written Comments Not Submitted.

Baptist Medical Center - Scottsdale

8435 East McDowell Road/Scottsdale, Arizona 85257/(602) 945-7600



OCTOBER 26, 1987

HCFA
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

RE: Mortality Data
Hospital No: 030063

Dear Sir:

Enclosed is a copy of the recent Mortality Data sent to Baptist Medical Center-Scottsdale. After careful review of the data, the following information is provided to address the area SE-2 cases - 100%.

Both of these cases were reviewed in detail and by our Quality Assurance and Mortality Committee which concur that there were extenuating circumstances in both of these cases of multiple and underlying serious illnesses accompanying the diagnosis of Sepsis. These additional diagnosis do not appear however as a principal diagnosis but as secondary diagnoses. Your information appears to have been taken from the principal diagnosis.

Additionally as you know a small sample tends to favor extremes at both ends of the scale.

We are confident that both of these patients received quality care.

Sincerely,


Allen S. Nohre
Administrator

ASN:ml



"Man and Medicine"

CASA GRANDE REGIONAL MEDICAL CENTER

1800 EAST FLORENCE BOULEVARD • CASA GRANDE, ARIZONA 85222
(602) 426-6300

October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Washington, D.C. 20201

Re: HCFA Mortality Data Comments
Provider Number 030016

Dr. Roper,

Data used by HCFA indicate that a total of 72 Medicare patients expired within 30 days of hospitalization. Of these, 26 (36%) expired after discharge from our facility. Our records show that 1048 Medicare admissions occurred in 1986; HCFA data show 708 Medicare admissions. Presumably, the discrepancy reflects multiple admissions of individual beneficiaries to different hospitals. We have no way of verifying the number of Medicare patients who expired within 30 days of discharge.

HCFA data show that our mortality rates by Diagnostic Category are well within the Range of Predicted Mortality Rates. With the exception of one Category, our rates were in the lower to middle of the range. Diagnostic Category of Cancer (CA) shows our mortality rate to be 43% with a Predicted Range of 11-44%. We feel this is due, in part, to the lack of hospice type services in the community which provides end-stage care for patients in the home.

While we feel that this study provided somewhat interesting data, we do not feel the study should be used as a measurement of quality care provided by our facility.

Sincerely,

Robert F. Theilmann
Administrator

'WE CARE'

Community Hospital

P.O. Box 1388
Wickenburg, AZ 85358

October 14, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Sir:

In reviewing the mortality data for our hospital, one error was found. [REDACTED] expired while hospitalized on 9-15-86, not on 9-30-86.

We reported this error to our F.I. They are working to correct it.

Sincerely,



T. Meeker, RRA
Manager, Medical Record Services

TM:ch

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.



Copper Queen Community Hospital

101 Cole Avenue
Bisbee, Arizona 85603
(602) 432-5383

October 27, 1987

HCFA Mortality Data/HSQB
Hospital Mortality Information
6300 Security Boulevard, Room 2D2
Meadows, East Building
Baltimore, Maryland 21207

RE: HCFA Mortality Data

Gentlemen:

Enclosed is the following information:

Guide for HCFA Mortality Data Comments (completed)

Review of Mortality Statistics for Medicare Patients
Treated in 1987

If you have further questions on the above, please contact us.

Sincerely,

Phil Mears
Administrator

Enclosures

PM/if

cc: Mrs. Eleanor Vlahovich, U.R./Q.A. Coordinator



ARIZONA HOSPITAL ASSOCIATION

Interstate Corporate Center

2411 West 14th Street / Suite 410 / Tempe, Arizona 85281-6943 / Phone (602) 968-1083

Guide for HCFA Mortality Data Comments

Data Verification

The data used by HCFA indicate that a total of 37 Medicare patients admitted to CQCH hospital died within 30 days of admission. Of these, 33 died while still a patient of the hospital, while 4 died after discharge. Our own records indicate that 420 Medicare admissions occurred in 1986. Presumably the discrepancy reflects multiple admissions of individual beneficiaries to different hospitals. (We have ~~no way of~~ ^{led} verifying whether the number of Medicare patients treated at CQCH hospital is correct.) Our own records also indicate that of the 4 Medicare patients who died within 30 days of admission while still inpatients, 4 were still alive at the time of discharge. (Note: the hospital should submit to HCFA a corrected copy of the patient listing clearly identifying any patients mistakenly coded as dead at the time of discharge.) It is impossible to determine the percentage of the 4 patients dying after discharge who were in fact alive, as information concerning death after discharge is not included in the patient's medical record.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

Interpretive Remarks

In none of the diagnostic categories, the hospital's actual mortality rate falls outside of the range of the predicted mortality rate. After correcting the errors in the recording of deaths, the number of categories in which the actual mortality rate is outside the range of the predicted mortality rate falls to . Several factors may account for this difference. (Select relevant factors and briefly elaborate.)

- o A small sample tends to favor extremes at both ends of the scale.
- o Unique services resulting in higher than average mortality i.e., programs specializing in treatment of patients with terminal or extremely acute conditions.
- o A lack of skilled nursing beds in the area which accounts for more patients with chronic degenerative conditions being admitted shortly before death.
- o A higher severity of illness or higher than average risk of death for patients treated.
- o A high percentage of post discharge deaths not directly related to the condition for which the patient was treated.

(If you have any one or two categories that are abnormally high, it may dramatically affect your overall mortality rate for "all causes." Depending on your ability to explain the individually high rates, you may want to drop them out and refactor your overall rate.)



COPPER QUEEN COMMUNITY HOSPITAL

101 COLE AVE. — BISBEE, ARIZONA 85603 — (602) 432-5383

Date: 10/20/87

Medicare provider number: 030027

To whom it may concern:

Review of mortality statistics for Medicare patients treated in 1986

A total of 37 patients were listed

33 died in the hospital

4 died within 30 days of last discharge

1 record: Entered under wrong category by HCFA

7 records: The cause of death was not related to the reason for admission.

21 records: Found to be correctly coded and cause of death related to reason for admission.

These records were fully reviewed again and our Hospital wishes to make the following comments.

- I. The 4 persons who died outside the hospital(no contact was made with families or their physicians) should not be included in these statistics because:
 - a. Some terminally ill patients prefer to die at home with Home Health Services.
 - b. Our Physicians feel that the fact that these patients died within 30 days of discharge, does not reflect in any way on the Quality of Patient care rendered. These 4 patients had an average 10 day stay at home before death.
- II. Many of the patients who died, died with correctly documented diagnoses for that admission, however, the underlying problem was not reflected in the Principal diagnosis, a terminal illness.
- III. Coding procedures for DRG's under the direction of HCFA reflect only: The principal Diagnosis; after study, that which precipitated the admission of the patient. This frequently does not relate to the "Cause of Death".
- IV. Severity of illness was not included as a determining factor in these statistics. Our physicians feel this is an extremely potent factor when reviewing deaths.
- V. Our hospital questions the value of the HCFA figures for the above listed reasons, and feel that in no way do they reflect the quality of patient care rendered.

ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

Desert Samaritan Hospital & Health Center

October 23, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

RE: MEDICARE PROVIDER NUMBER 030065

Dear Doctor Roper,

Desert Samaritan Hospital has concerns regarding the publishing of selected mortality information in December 1987. These concerns include:

Data does not allow for case severity adjustments.

Presence or absence of co-morbidities taken from the coding does not allow for the inherent problem of interpretation of coding principles. A surgical patient could have a significant co-morbid condition prior to admission that could adversely affect his outcome but due to coding principles it would be documented and identified only as a postoperative complication contributing to the death.

The cause of an illness is affected by a variety of circumstances, many of which may not have anything to do with the patient's hospital care, social factors etc.

The use of the 30 day post admission window allows for non-hospital related conditions to adversely influence the mortality rate.

The fact that a patient died within 30 days of hospitalization does not necessarily reflect the quality of care received unless you have a method to ascertain how sick the patient was prior to being admitted.

The hospital cannot verify the accuracy of HCFA's statistics on deaths after discharge because we do not have access to the Social Security data that HCFA used.

It is impossible to single out a small piece of health care management - the last hospital stay - to measure quality of care overall.

1400 South Dobson Road • Mesa, Arizona 85202 • (602) 835-3000
A DIVISION OF SAMARITAN HEALTH SERVICE

page two

It is unclear if the data time period, 1 year, represent the true average results over a substantial period of time. It is also unknown if the volume of service by category is large enough to be meaningful.

Data does not analyze the impact of hospital size, scope of hospital services provided and utilization levels of services on patient outcome.

At Desert Samaritan Hospital, we are extremely proud of our commitment to quality care. In accordance with the Medical Staff and Governing Board we have developed a Quality Assurance Program to promote high quality patient care. Goals of this program include:

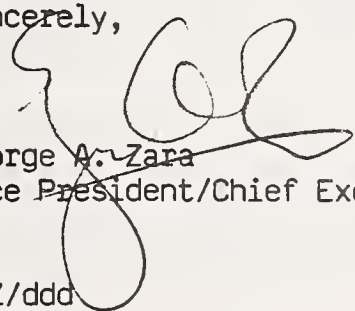
- To improve quality of care and utilization of hospital resources.
- To promote programs and services most beneficial to our patients.
- To prevent personal injuries and limit risk.
- To comply with laws and regulations of government agencies and standards of hospital accreditation organizations.

We acknowledge that the quality of hospital care cannot be easily measured - the standard is not absolute. Every patient and admission is different and the care received is a complex conglomerate of human and technological services. Desert Samaritan Hospital has in place a comprehensive Quality Assurance Program that monitors all admissions including morbidity/mortality data, infection control surveillance activities, continuing medical education, pharmacy and therapeutic drug review activities, and justification review of surgical procedures, admission and discharges.

Although the publishing of mortality information at this time may, under expert interpretation, provide the public access to some knowledge about death predictability it cannot estimate with any substantial degree of accuracy the probability of a hospital to provide a predictable level of care. The lack of case severity adjustments for this data may significantly mislead the public and inappropriately place hospitals in an imponderable position in their community.

Thank you for the opportunity to respond to HCFA publication of data. We would be happy to discuss the elements of our concern with any one requesting this information after publication.

Sincerely,



George A. Zara
Vice President/Chief Executive Officer

GAZ/ddc
1925A

October 27, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

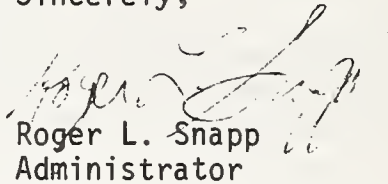
Dear Dr. Roper:

El Dorado Hospital's mortality rate falls well within the predicted range in all diagnostic categories. In fact, the mortality rate for all causes is 9 percent, mid way in the predicted range.

The only category where the mortality rate was on the high end of the predicted range was severe chronic heart disease. In this category 18 of the 21 patients were admitted with congestive heart failure, another two were admitted with cardiomyopathy and 13 out of the 21 were over 75 years of age. All of these statistics may be indicators of a higher severity of illness or greater than average risk of death. These factors are not reflected in the HCFA statistics.

While the current HCFA mortality data are helpful to hospitals as a way to identify areas for further evaluation, they are not an absolute measure of quality. Until an acceptable method of measuring severity of illness and other comorbidities is developed, the HCFA mortality data cannot be viewed as an indicator of quality of care. In addition, the reliability of the model used to construct the HCFA data is a major concern. In short, the HCFA mortality data provides more questions than answers.

Sincerely,


Roger L. Snapp
Administrator

RLS/eb



FLAGSTAFF HEALTH MANAGEMENT CORPORATION

P.O. Box 1268, 1215 North Beaver Street, Flagstaff, Arizona 86002, Telephone: (602) 779-3366

FLAGSTAFF MEDICAL CENTER FOUNDATION FOR FLAGSTAFF MEDICAL CENTER GUARDIAN HEALTH SERVICES, INC.

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Washington, D.C. 20201

Dear Doctor Roper:

This letter is in response to HCFA's report of mortality data on Medicare patients treated at Flagstaff Medical Center in 1986.

The data used by HCFA indicate that a total of 62 Medicare patients admitted to Flagstaff Medical Center died within 30 days of admission. Of these, 49 died while still a patient of the hospital, while 13 died after discharge. It is not possible to determine the accuracy of the patients reported to have died after discharge, as post-discharge information is not included in the patient's medical record. Also, alternative causation for post-discharge deaths must be ruled out in order to arrive at a valid hospital mortality rate. Furthermore, lacking detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data in the HCFA analysis.

Overall, Flagstaff Medical Center's actual mortality rate falls well within the range of the predicted mortality rate in each of HCFA's diagnostic categories.

While the current HCFA mortality data are helpful to hospitals and consumers as a way to identify areas for further evaluation, they should not be used as an absolute measure of quality. The time period being studied is still too short to show consistent trends. The lack of an acceptable method for measuring severity of illness and other comorbidities also hampers this effort. The still unknown reliability of the model that HCFA used to construct these data is of major concern. Finally, until the HCFA model is validated, quality judgements can be made only on the basis of a case-by-case review of each patient's medical record.

The Board of Directors, medical staff and hospital staff of Flagstaff Medical Center are committed to the consistent delivery of quality patient care as reflected in the mission and goals statement and exemplified in the comprehensive quality assurance program. This system establishes an ongoing, objective method of routine monitoring and evaluation of all

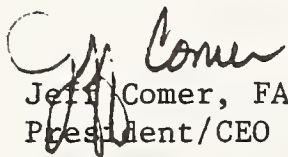
William L. Roper, M.D.
Page 2

October 26, 1987

important aspects of care in order to identify and pursue each opportunity to improve care. Review of all patients deaths is only one aspect of the hospital-wide quality assurance program. Documentation is routinely maintained of the process and outcome of Flagstaff Medical Center's quality monitoring activities.

Thank you for this opportunity to comment on the HCFA mortality data.

Sincerely,


Jeff Comer, FACHE
President/CEO

JC/mpt



October 26, 1987

To the Interested Public:

This letter contains additional information regarding the attached mortality data of medicare patients treated in Good Samaritan Medical Center during 1986.

Good Samaritan Medical Center is a 669 bed tertiary acute care facility located in Phoenix, Arizona. Its case mix includes many patients with major medical and surgical illnesses. GSMC is a full service medical center offering care in specialty areas such as trauma, open heart surgery, oncology, rehabilitation medicine, dialysis, organ transplantation and orthopedics. Good Samaritan Medical Center discharged a total of 33,885 patients during 1986, of which 6,147 were medicare patients. The attached information represents a review of 4,910 of those medicare patients.

Good Samaritan Medical Center has been proactive in assuring quality of care through an ongoing process of the Quality Assurance Program. The care of every patient is reviewed while they are in the hospital by qualified physicians and registered nurses. In addition, the care of each patient is reviewed after discharge to further evaluate patient outcomes relative to the care that was provided.

The hospital specific mortality data reported by HCFA has been carefully reviewed by hospital administration, the physician chairman of the quality assurance committee, and the director of quality assurance/utilization review. Our overall percentage of death is well within the range expected for a hospital with the size and complexity of Good Samaritan Medical Center. In most cases the percentages are in the low end of the range.

Sincerely,

A handwritten signature in dark ink, appearing to read "Richard B. Uhrich".

Richard B. Uhrich, M.D.
Senior Vice President/
Chief Executive Officer

A handwritten signature in dark ink, appearing to read "Robert Westfall".
Robert Westfall, M.D.,
Chief of Staff

JLH/ph

Humana Hospital Desert Valley

October 27, 1987

William Roper, M.D., Administrator
Health Care Financing Administration
Department of Health & Human Services
Washington D.C. 20201

Dear Dr. Roper:

Thank you for the opportunity to comment on the hospital specific mortality data provided to us late last month. Humana Hospital - Desert Valley supports the Health Care Financing Administration's desire to educate those interested in Medicare quality issues. We recognize this program is early in its development stages. While its measurements are preliminary and rough, it is clearly an example of the type of quality measurements to come.

This information is helpful in our hospital's ongoing quality assurance program that includes regular and complete review of all admissions which result in patient mortality, regular morbidity and mortality reviews, quality assurance, utilization review, as well as complete outside review by the Joint Commission on Accreditation of Health Organizations and other outside review organizations.

Since these raw numbers reflect deaths which occurred in only a limited segment of a hospital's patient population (the elderly) and are not adjusted for severity of illness or other factors which may affect patient outcome, they must be considered in that context and should serve as only one of numerous indicators used to review the quality of services provided at an individual hospital. While this statistical data is useful in this format for professional evaluation, it is not beneficial for consumer use. As a result, consumers should be informed as to the limited scope of these numbers, and be cautioned about drawing any conclusions from the data about the quality of a particular hospital's services.

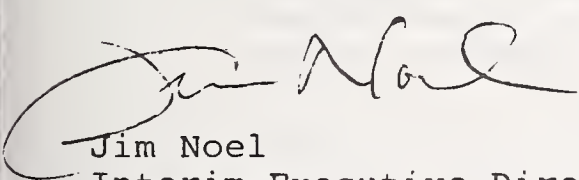
William Roper, M.D., Administrator
October 27, 1987
Page Two

As in all deaths occurring in hospitals, a complete internal review is necessary to determine the appropriateness of the outcome and may provide information to physicians and other medical providers about improvements which can be made in treating future patients. Thus, the use of raw mortality statistics is helpful to professionals in identifying patient trends and treatment outcomes. Additionally, they may assist health care consumers in understanding the extensive quality control systems in place in hospitals.

Our hospital's Quality Assurance Department has reviewed the data. Since some deaths occurred outside the hospital (26 of the 138 or 19%), we have been unable to completely validate this data. Generally, we have found it to be consistent (with some exceptions) with our hospital records. Unfortunately, in most cases the number of patients in a particular category is too small (in 11 categories there are less than 10 patients) to provide a valid statistical analysis. In addition, the predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner, it would be inappropriate to consider them acceptable or unacceptable "standards". The assumption is made that these deaths are a negative outcome. This quite often is not the case. Internal peer review in addition to statistics is necessary to appropriately evaluate data and determine quality and appropriateness of care provided.

I hope this information will be helpful in attempting to refine the collection and reporting of raw hospital data. In addition, our hospital will do everything possible to assist our community in understanding how this data can best be used to improve health care services.

Sincerely,



Jim Noel
Interim Executive Director

/lv

OCT 28 '87 13:53 HUMANA PHX

1911 East Thomas Road
Phoenix, Arizona
85016
Telephone 602.241-7600

P. 1
Pg. 1 of 2

Humana Hospital Phoenix

October 27, 1987

William L. Roper, M.D.
Administrator, Health Care
Financing Administration
Dept. of Health & Humana Services
Attention: HSQ-148-GNC
6325 Security Boulevard
Baltimore, Maryland 21207

Dear Doctor Roper:

Thank you for the opportunity to comment on the hospital specific mortality data provided to us late last month. Humana Hospital - Phoenix supports the Health Care Financing Administration's desire to educate those interested in Medicare quality issues. We recognize this program is early in its development stages. While its measurements are preliminary and rough, it is clearly an example of the type of quality measurements to come.

This information is helpful in our hospital's ongoing quality assurance program that includes regular and complete review of all admissions which result in patient mortality, regular morbidity and mortality reviews, quality assurance, utilization review, as well as complete outside review by the Joint Commission on Accreditation of Health Organizations and other outside review organizations.

Since these raw numbers reflect deaths which occurred in only a limited segment of a hospital's patient population (the elderly) and are not adjusted for severity of illness or other factors which may affect patient outcome, they must be considered in that context and should serve as only one of numerous indicators used to review the quality of services provided at an individual hospital. While this statistical data is useful in this format for professional evaluation, it is not beneficial for consumer use. As a result, consumers should be informed as to the limited scope of these numbers, and be cautioned about drawing any conclusions from the data about the quality of a particular hospital's services.

P.2
Pg. 2 of 2

Page Two
William L. Roper, M.D.
October 27, 1987

As in all deaths occurring in hospitals, a complete internal review is necessary to determine the appropriateness of the outcome and may provide information to physicians and other medical providers about improvements which can be made in treating future patients. Thus, the use of raw mortality statistics is helpful to professionals in identifying patient trends and treatment outcomes. Additionally, they may assist health care consumers in understanding the extensive quality control systems in place in hospitals.

Our hospital has reviewed the data. Since some deaths occurred outside the hospital, we have been unable to completely validate this data. Generally, we have found it to be consistent with some exceptions with our hospital records. Unfortunately, in most cases the number of patients in a particular category is too small to provide a valid statistical analysis. In addition, the predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner, it would be inappropriate to consider them acceptable or unacceptable "standards."

I hope this information will be helpful in attempting to refine the collection and reporting of raw hospital data. In addition, our hospital will do everything possible to assist our community in understanding how this data can best be used to improve health care services.

Sincerely,

Raymond A. Rouleau, Jr.
Executive Director

/m

cc: Patrick Stone
Si. Paul Affairs Org.
Corp.

HCFA MORTALITY DATA COMMENTS

Hospital ID Number 030014

Interpretive Remarks

John C. Lincoln Hospital and Health Center is a full service hospital with 282 beds and a Level I Trauma Center. The Trauma Center at Lincoln has served the community well by saving lives that might have been lost in a traditional emergency room setting. Because of the Trauma Center, Lincoln's Emergency Department tends to attract and treat sicker patients.

Over sixty percent of the patients HCFA listed as having died were admitted through Lincoln's Emergency Department.

General Comments

The administration of Lincoln Hospital feels compelled to comment on the validity of the HCFA data as a measurement of the quality of care given by a hospital.

Quality of care given by a particular hospital should not be measured solely on the basis that a patient died within 30 days of being discharged by a variety of circumstances. The care delivered by a hospital is but a part of a patient's total healthcare experience.

Other critical factors which affect clinical outcome are: the patient's personal healthcare regimen; social factors; preventive healthcare measures; patient compliance with treatments; and timeliness of diagnosis, outpatient treatment, and hospital admission.

Data Verification

In verifying the data, Lincoln Hospital found an overall error rate by HCFA of six percent.



KENNECOTT SAMARITAN HOSPITAL

A Division of Samaritan Health Service
100 TILBURY DRIVE / BOX 368 / KEARNY, ARIZONA 85237 / (602) 363-5573

October 23, 1987

Mr. William L. Roper, M.D.
Administrator
Department of Health & Human Services
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Dear Dr. Roper:

The mortality data for our institution represents an extremely small sample and, therefore, is not a valid indication of the quality of care delivered.

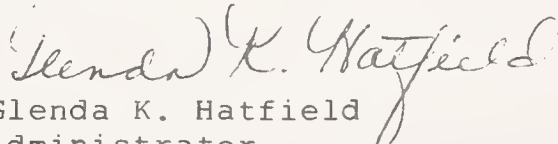
Our rural institution often accepts patients from the metropolitan area who wish to spend the short remainder of their life in a facility where their families/friends have the ability to visit. (There are no long term care facilities in our area.) Our Swing Bed Program allows us to deliver this very valuable service.

Since only one cancer patient -- who was admitted to the institution to spend the remaining portion of his life -- is listed in the mortality data, the 100% rate for CA paints an inaccurate picture of the quality of service delivered in our institution.

Another of the patients listed suffered an accident after discharge from this institution that contributed towards the cause of death.

These two cases represent 50% of the very small sample from our institution. Mortality data reported for our institution does not illustrate the quality of care delivered because of the character of our institution and the very small sample it represents.

Sincerely,


Glenda K. Hatfield
Administrator

GKH/ag



October 20, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Department of Health and Human Services
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for the opportunity to respond to mortality information prior to publication in December 1987. I offer the following information in an attempt to help you prevent the publication of inaccurate information. I appreciate your requesting our input to help eliminate any discrepancies in the data used to analyze this information.

The data used by HCFA indicates that a total of 649 Medicare patients were treated at Kino Community Hospital in 1986 and that 107 Medicare patients were admitted and died within 30 days of that admission. Of these, 74 died while still a patient at the hospital, while 33 died after discharge. Our records indicate that 4 of the patient deaths being attributed to Kino Community Hospital were patients transferred to the Veteran's Administration Medical Center in Tucson. These are as follows:

ID#: [REDACTED]
Surname: [REDACTED]
Diagnostic Category: CA
Date of Admission: 05/24/86
Date of Discharge and
Transfer to VA: 05/26/86

ID#: [REDACTED]
Surname: [REDACTED]
Diagnostic Category: HS
Date of Admission: 07/21/86
Date of Discharge and
Transfer to VA: 07/25/86

2800 East Ajo Way
Tucson, Arizona 85713
(602) 294-4471

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

ID#: [REDACTED]
Surname: [REDACTED]
Diagnostic Category: HS
Date of Admission: 09/05/86
Date of Discharge and
Transfer to VA: 09/15/86

ID#: [REDACTED]
Surname: [REDACTED]
Diagnostic Category: PN
Date of Admission: 09/05/86
Date of Discharge
and Transfer to VA: 09/08/86

In the category HS, Severe Acute Heart Disease, besides having 2 patients discharged from this hospital and transferred to the Veteran's Administration Medical Center, there are 3 additional patients who expired within the first three hours of their admission. In other facilities, these patients might have been cared for in the Emergency Department, not admitted to the hospital, leading one to believe that these patients were severely ill. After correction for this inaccurate information, Kino Community Hospital would have no diagnostic category outside the range of the predicted mortality rate.

In addition to the above, our records reflect 2 death dates that were incorrectly stated by HCFA information.

ID#: [REDACTED]
Surname: [REDACTED]
Diagnostic Category: CA
Date of Discharge: 11/22/86
Date of Death: 11/27/86 Listed by HCFA
Actual Date of Death: 11/22/86 Patient expired at Kino
Hospital

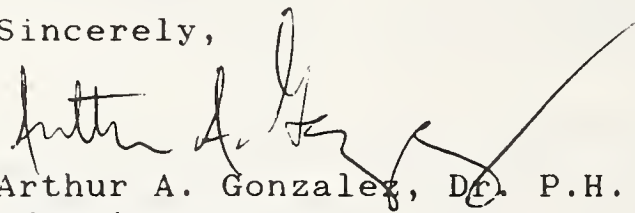
ID#: [REDACTED]
Surname: [REDACTED]
Diagnostic Category: UN
Date of Discharge: 08/20/86
Date of Death: 08/22/86 Listed by HCFA
Actual Date of Death: 08/20/86 Patient expired at Kino
Hospital

William L. Roper
October 20, 1987
Page 3

Additionally, as the number of cases in each diagnostic category is quite small, the actual mortality rate as stated by HCFA may be statistically incorrect due to the small numbers. In conclusion, without detailed information concerning the data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of diagnostic or other data used in the analysis.

Again, thank you for the opportunity to submit this information.

Sincerely,



Arthur A. Gonzalez, Dr. P.H., FACHE
Administrator

/lo

cc: File

Enclosures



Lewis R. Pyle Memorial Hospital, Inc.

807 SOUTH PONDEROSA, PAYSON, ARIZONA 85541

PAYSON (602) 474-3222

October 29, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Gentlemen:

To the extent we can verify your numbers with statistics we keep, the numbers are correct. The data used by you indicate that of the 485 Medicare patients admitted to our hospital a total of 40 died within 30 days of admission. Of these, we can verify 26 died while still a patient of the hospital, which leaves a remainder of 14 you are reporting as died after discharge which we have no way of verifying. Our records indicate 829 Medicare admissions occurred in 1986. Presumably the discrepancy reflects multiple admissions of individual beneficiaries to our hospital.

In all categories our hospital is below or within the predicted range. However, these are only statistics and, we feel, in no way reflects quality of care in a hospital.

We do have an active Quality Assurance Committee who receives quarterly reports of studies made by all departments in the hospital. These are reviewed, studied and acted upon, when necessary, or recommendations are made by the committee. The work of this committee is monitored by our Board of Directors.

Sincerely,

Mary DeLano
Assistant Administrator

MD:nw

OFFICE OF THE PRESIDENT

October 23, 1987

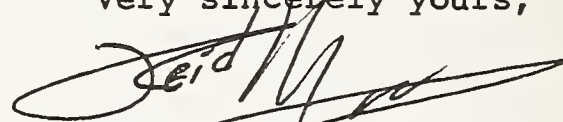
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Hospital Provider No. 030007

Comments concerning the mortality data to be published by
HCFA in December:

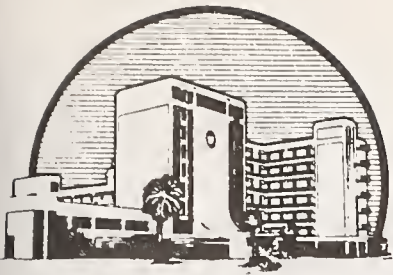
As indicated by the statistics in this release, Marcus J. Lawrence Memorial Hospital is well within the low to medium range of expected mortality percentages. Just the same, we believe that it is prudent to make the following comments regarding the methodology employed by HCFA. First, the HCFA statistical model fails to consider a range of factors which impact directly on mortality, such as the stage of a patient's illness and the patient's general health. In our case, the fact that we have a dialysis unit within the facility and treat end stage renal disease patients, and operate a Hospice program, and that we treat a high proportion (60-65%) of Medicare patients, are not accounted for by HCFA. Second, the model includes all Medicare patient deaths within 30 days following admission, no matter what the length of stay or whether or not death occurred from an unrelated cause. In our case, 27.5% of our attributed deaths were after discharge. Finally, it is unclear how HCFA or the PRO's or any other government agency plan to give insight into mortality and morbidity statistics, when such has been reviewed for years by medical staff committees.

Very sincerely yours,



Reid M. Wood
President

RMW:cr



MARICOPA MEDICAL CENTER

2601 EAST ROOSEVELT P.O. BOX 5099 PHOENIX, ARIZONA 85010 267-5011

October 26, 1987

Department of Health and Human Services
William L. Roper, M.D., Administrator
Health Care Financing Administration
Washington, DC 20201

Medicare Provider Number: 860311515

Dear Dr. Roper:

In September you wrote about the release of mortality data suggesting the information would be of value to hospital administrators and staffs, physicians, professional societies, researchers and consumers. We disagree with the potential value you've assigned this information. Your letter contained numerous disclaimers including "...we can not and do not recommend the use of the information by itself to make judgments about the quality of care in an individual hospital or to make comparisons among hospitals." Until your model is available for public scrutiny and errors in your raw data are eliminated, your mortality data will likely be misused.

I applaud the efforts of the Health Care Financing Administration (HCFA) towards the development of mathematical models to evaluate the quality of patient care delivered at hospitals. We at Maricopa Medical Center also share a keen interest in the development of data systems useful in the measure of quality patient care. Approximately one and one-half years ago we began a joint project with a private consultant to develop our own mathematical model (namely, QOMIS-Quality, Operations, and Marketing Information Systems) that allows us to look at a wide variety of quality of care issues. We utilized nationally available data to develop the QOMIS. This project started prior to HCFA's first release of mortality statistics approximately one year ago. We utilized the results internally as an interesting evaluation of heretofore unavailable statistical information. We have not published our data because we realize that such information is potentially damaging while the model is still in the developmental stage. However, the HCFA has chosen to release quality of care information still undergoing active development and "debugging". We believe release of such data is a great disservice to consumers, physicians, and institutions. While the data you have produced may be academically interesting and a bit of a statistical marvel, the utility, by your own admission, is yet to be proven. As a consequence, patients may suffer both emotionally and physically from changed physician practice patterns resulting from your incomplete data.

Our hospital was a few percentage points over the maximum predicted overall mortality. We were more than a few percentage points over your maximum predicted mortality in your category of "pulmonary diseases". Because of the substantial number of cases that fell into this category I assume (since the actual mathematical model is not available for institutional review) this category impacted our overall mortality rate and probably is the reason our overall rate was above predicted. Given the time restraints imposed for our analysis of this information we reviewed the medical records and our internal quality assurance information on the one-hundred-seven mortalities listed in your category of "pulmonary diseases". One interesting discrepancy immediately evidenced by review was the patient identified by HIC Number [REDACTED] is not deceased and visited our ambulatory clinic during the month of September 1987. No other substantive discrepancies were found in the data we reviewed.

In our statistical review of the one-hundred-seven mortalities in your "pulmonary diseases" category we noted the average age of the patients at the time of their death was over seventy-nine years. Considering the average life expectancy at the time of birth is in the neighborhood of seventy-four years, we wonder what conclusions are to be drawn from mortality data. The assumption that death, in and of itself, is a negative quality indicator is a common misconception. One does not have to be a physician to realize that the natural end of everyone's life is death. I understand age was controlled for in your mathematical model; however, there is no way to control for the fact that mortality may not be a useful quality indicator across all patient categories.

A substantial factor absent in your mathematical model is the mode of admission. In Arizona, counties bear the obligation of providing long term care services to our elderly population. As the county hospital for Maricopa County, we provide the secondary and tertiary inpatient services to this elderly, nursing home population. Additionally, most of our hospital admissions are via our emergency room. Neither factor, emergency room admissions or nursing home admissions, was considered in the data you presented.

From our QOMIS data, utilizing 1985 California Medicare data, we demonstrated a 3.34-fold increase over the expected mortality for patients residing in nursing homes who were admitted via an emergency room compared to patients admitted from home as non-emergencies for diagnoses falling in the "pulmonary diseases" category. Looking at Chronic Obstructive Pulmonary Disease (COPD) within the California data, a 7.98-fold increase in expected mortality is noted for patients admitted from a nursing home via an emergency room compared to patients admitted from home as a non-emergency. Your disregarding patients admitted via the emergency room from a nursing home appears to be a substantial deficiency given the impact this factor alone can have on mortality data. Obviously, individuals residing in skilled nursing home facilities are chronically debilitated and at a higher risk of mortality.

In reviewing "pulmonary diseases" mortalities, we found ninety of the one-hundred-seven patients were from nursing homes, and seventy-six of the nursing home patients were admitted via our emergency room. Fourteen of the

patients were nursing home residents admitted to another institution and subsequently transferred to Maricopa Medical Center. Four of the patients were non-nursing home residents transferred to Maricopa Medical Center from other local hospitals. Finally, thirteen of the patients were admitted from the community via our emergency department. All patients in the mortality group were admitted via our emergency room or as a transfer from another institution. The availability of services, the severity of a patient's condition, and economic factors all impact the decision process behind hospital-to-hospital transfers. We doubt you adequately controlled for all these factors. Since the mode of admission was not taken into consideration in your data, we believe a significant bias exists.

Another factor omitted from your data tied closely to my earlier comments on death being the natural and expected end to life. The State of Arizona recognizes the rights of patients to establish a living will. Maricopa Medical Center supports the living will doctrine. Of the seventy-six patients from nursing homes mentioned above, twenty-five percent arrived at our hospital with a Do Not Resuscitate (DNR) designation established at the nursing home. This means, based on a physician's order after consultation with the patient, the patient's family and/or guardian, that a patient who dies will not be given artificial life support. Of that same seventy-six patients, fifty (65.8%) had a DNR status established after their admission to Maricopa Medical Center. Only seven of the one-hundred-seven deaths in the "pulmonary disease" category never had a DNR status established prior to the time of their death. Physicians at Maricopa Medical Center rightly oppose heroic and artificial measures to sustain life if the only possible outcome is to prolong the dying process and not to promote life. The right of every patient to a dignified death without being caught in the futile application of medical technology is one that should be, and must be, actively supported.

I am forming the distinct impression that practice patterns at many hospitals may well be changed as a result of your mortality data. However, sadly, I believe the desired result will not be achieved. With institution-specific mortality data currently available and physician-specific mortality data on the horizon I fear the effect of your reports may be the denial of hospital admission to patients nearing the end of their life. Rather, those patients may well be allowed to die in emergency rooms or shipped back to a nursing home to await their fate. I do not believe this was the intent of the HCFA; however, I fear this may be a consequence.

Sincerely,



Ace M. Hodgin, Jr., M.D.
Medical Services Administrator
Director of Medical Education

QA44/32



Lutheran Healthcare Network

Mesa Lutheran Hospital

525 West Brown Road
Mesa, Arizona 85201
(602) 831-1211

MEMORANDUM

TO: Department of Health & Human Services
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

FROM: Richard Probst, Administrator
Mesa Lutheran Hospital

Claytona Stockdale, Director, Utilization Management
Lutheran Healthcare Network

RE: Mesa Lutheran Hospital
HCFA Mortality Data

This memo is in response to the release of mortality data which is relevant only to Mesa Lutheran Hospital. After receiving the data which is inclusive of Medicare patients whose last admission was to our hospital and who died within 30 days of that admission, we researched and made the foregoing conclusions.

DATA VERIFICATION

The data submitted by HCFA indicates a total of 3,678 Medicare patients were admitted to our hospital. Our records indicate that 5,054 Medicare admissions occurred in 1986. It is our feelings, the discrepancies between HCFA's "All Causes-3,678" and our Medicare admissions of 5,054 reflects multiple admissions of individual beneficiaries.

The HCFA data indicates a total of 382 Medicare patients admitted to Mesa Lutheran Hospital died within 30 days of admission. We verified this figure and found although the admission dates of a few were incorrect, the total was correct. Of these 382 patients, we verified that 320 died within their respective hospital stay. In 1 case, the patient died at a neighboring hospital. Of the 382 patients, 65 died after discharge.

We were able to verify, with the assistance of physicians and local hospitals, the deaths of 48 out of 65 patients who expired outside of this institution. After extensive research, we found that 28 were sent home designated as "No Code" status, 3 died in ER in "code status", 10 were disease related and 17 were not verifiable due to lack of physician documentation. We were not able to track 17 patients since they were residents outside the state of Arizona (as you know, the metropolitan Phoenix area experiences an influx of seasonal visitors October through March each year). All of the 65 patients received appropriate discharge planning to home health, extended care, long term care, and home assistance.

Due to the extensive man hours and subsequent cost to research and validate each of these 382 patients, we selected to verify the data based on 5 of the data variables, utilizing a sample size of 120 patients. We found the following inaccuracies:



Lutheran Healthcare Network

Mesa Lutheran Hospital

525 West Brown Road

Mesa, Arizona 85201

(602) 831-1211

of ERRORS

Sex:	1
Date of Death:	12
Date of Admission:	2
Date of Discharge:	2
Principle Diagnosis:	8

The errors for principle diagnosis fell into the categories of Orthopedic (OP), Pulmonary (PM), Cerebrovascular (CE), and Uncategorized (UN). These 8 cases would minimally alter our mortality percentage.

Since our organization (Lutheran Healthcare Network) endorses the MEDISGRPS Severity of Illness Index, we decided to correlate the sample cases (120) with the corresponding Severity of Illness Index. As you may know, MEDISGRPS is based on "key clinical findings" which places a patient's diseases process into a severity of illness range between 0-4. Zero severity means patients admitted for symptoms with no objective findings or elective procedures. One severity means patients with a few abnormal findings and the likelihood of going into organ failure is remote. Two severity means patient with significant findings who may go into organ failure in the immediate future. Three severity means patients with severe findings who are in single organ failure. Four severity means patients with critical findings indicating the presence of multi-system organ failure.

Our severity of illness verified that these 120 patients fell into the range greater than 1 and less than 4 with an average of 2.69. Of the 65 patients discharged, their average severity of illness was 2.33. Thus, patients who expired in-house had documented clinical findings which could have and did result in death. The discharged patients, based on MEDISGRPS, also had the potential of mortality.

INTERPRETIVE REMARKS

Mesa Lutheran Hospital does not fall outside the predicted mortality rate in any category.

In our investigation, we discovered information that could effect the overall picture for any hospital's mortality rate. First, sex, diagnosis, and date of death were found to be incorrect within our sample. These factors could easily alter the mortality percentage. We found a severity of illness factor useful in validating the extent of illness. We discovered a patient that died in another facility. In this case, we wondered, did both hospital receive credit for the death? Or, was it the hospital that submitted the first bill? We found causes not related to illness such as a suicide. Finally, we found physicians to be very helpful in our efforts.

As a final point of interest, we did investigate those categories which appeared to be at the high point of the predicted range. Severe Acute Heart Disease was, for us, the most obvious. Once again, we researched each chart and verified the severity of illness at 2.69.

In closing, we would like to note that Mesa Lutheran Hospital has a Quality Assurance program that is systematic, planned, and ongoing which reviews case-by-case each hospital death, as well as, other key factors to protect our patients from negative outcomes. Our Quality Assurance model also provides a mechanism to improve the quality of care rendered.

Thank you for the chance to address this issue.

Sincerely,

Richard Probst

Richard Probst
Administrator

BS/rm

Kingman Regional Medical Center
(Mohave General Hospital)
Kingman, Arizona

Provider Number: 03-0055

The hospital's comments consisted primarily of annotations to the patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish the comments because of the numerous patient identifiers contained in the data.

**MT. GRAHAM
COMMUNITY
HOSPITAL**

L. L. JACKSON
ADMINISTRATOR

October 26, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Gentlemen:

Our comments on the HCFA Mortality Data are as follows:

Data Verification

The data used by HCFA indicate that a total of 50 Medicare patients admitted to MGCH hospital died within 30 days of admission. Of these, 36 died while still a patient of the hospital, while 14 died after discharge. Our own records indicate that 611 Medicare admissions occurred in 1986. Presumably the discrepancy reflects multiple admissions of individual beneficiaries to different hospitals. We have no way of verifying whether the number of Medicare patients treated at other hospitals is correct. Our own records also indicate that of the 53 Medicare patients who died within 30 days of admission while still an inpatient, 14 were still alive at the time of discharge. It is impossible to determine the percentage of the 14 patients dying after discharge who were in fact alive, as information concerning death after discharge is not included in the patient's medical record.

Analysis of Reporting Errors: See Enclosures

1. Analysis of Reporting Errors.
2. Cases Not Identified By HCFA.
3. Discrepancies in Diagnostic Category Per Hospital Records.
4. HCFA Listing.

General Comments:

While the current HCFA mortality data are helpful to hospitals and consumers as a way to identify areas for further evaluation, they should not be used as an absolute measure of quality. The time period being studied is still too short to show consistent trends. The lack of an acceptable method for measuring severity of illness and other comorbidities also hampers this effort. The

1600 TWENTIETH AVENUE • P.O. BOX 1019 • PHONE (602) 428-1171 • SAFFORD, ARIZONA 85548-1019

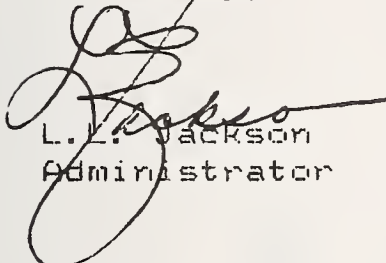
The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

Health Care Financing Administration
October 26, 1987
Page 2

still unknown reliability of the model that HCFA used to construct these data is of major concern. Finally, until the HCFA model is validated, quality judgements can be made only on the basis of a case-by-case review of each patient's medical record.

Our quality assurance and utilization review programs require appropriateness review for every admission. Quality of care is reviewed on a concurrent basis and every death is reviewed retrospectively.

Sincerely,

A handwritten signature in dark ink, appearing to read "L.L. Jackson", is written over the typed name and title.

L.L. Jackson
Administrator

LLJ:sf
Enclosures

Analysis of Reporting Errors

Diagnostic Category	Deaths Reported by HCFA		Deaths Verified by Hospital*	
	In-hospital	Post-hospital	In-hospital	Post-hospital
CA -- Cancer	4	2	5	2
CE -- Cerebrovascular Accidents	4	1	6	1
GC -- Gastrointestinal Catastrophes	3	1	3	1
GI -- Gastrointestinal Disease	1	0	2	1
GU -- Urologic Disease	-	-	-	-
GY -- Gynecologic Disease	-	-	-	-
HL -- Low Risk Heart Disease	1	1	1	1
HM -- Severe Chronic Heart Disease	3	1	4	1*
HS -- Severe Acute Heart Disease	5	2	6	2
ME -- Metabolic/Electrolyte Disturbances	-	-	-	-
OP -- Orthopedic Disorders	-	-	0	1
PN -- Pulmonary Disease	5	2	6	3*
RN -- Renal Disease	0	1	0	1
SE -- Sepsis	4	0	4	0
TR -- Severe Trauma	-	-	-	-
OP -- Ophthalmologic Disease	-	-	-	-
UN -- Other Diagnoses	6	3	2	0
Total -- All Categories	36	14	39	14
	Grand total 50		Grand total 53*	

NOTES: In the Deaths reported by HCFA, tabulate the number of deaths assigned to each diagnostic category on the individual care listing. In-hospital deaths are those patients whose date of discharge is the same as the date of death; post-hospital deaths are those patients whose date of death is after the date of discharge. Verified deaths should include those patients who are known to have died or whose status 30-days after discharge from the hospital cannot be determined. Verified deaths should also exclude patients that the hospital does not believe were ever admitted to the hospital.

* Three cases were not accounted for by HCFA (not on report)

Enclosure 2

THREE CASES NOT IDENTIFIED ON THE HCFA MORTALITY DATA REPORT.

	Patient I.D.#	Surname	Diagnostic Category	AGE	SEX	Admit Date	Disch Date	Death date	Principal Diagnosis
1.	[REDACTED]	[REDACTED]	HM	78	M	022686	022786	022786	CHF
2.	[REDACTED]	[REDACTED]*	UN	66	M	042186	042586	042586	Pancyto- penia.
3.	[REDACTED]	[REDACTED]	PN	80	M	062786	062886	062886	Pneumonia

* Has not been billed as of 3/87

Enclosure 3

Discrepancy in diagnostic Category per hospital record (principal diagnosis code)

Patient #	Surname	Diagnostic Category	Age	Sex	Date Admit	Date Disch	Date Death	Principal Dx	Principal Procedure
		HCFA HOSP							
	*	PN CE	87	F	090186	090286	090286	438	
		UN CE	93	M	020286	020286	020286	4379	
		UN PN	71	M	051986	052486	052686	4660	
		UN HS	73	M	052886	053086	0629086	3222	
		UN CA	82	M	040786	041486	041486	92401	
		UN GI	90	F	030986	031686	033186	7890	
		UN GI	81	M	091686	091986	091986	5770	
		UN OP	96	F	122985	010286	011786	8088	

* Billing in-put error (discrepancy quite significant)



NAVAPACHE HOSPITAL

2200 Show Low Lake Rd. • Show Low, Arizona 85901
(602) 537-4375

DATE: October 22, 1987

TO: HCFA
Health Standards Quality Bureau

FROM: M. Victoria Clark-*M. Victoria Clark*
Chief Financial Officer

RE: Hospital Mortality Data
Navapache Hospital ID #030062

The data used by HCFA indicates that mortality statistics for Navapache Hospital Medicare patients during 1986 fell within the predicted range of percentage of patients who would have been expected to die given adjustments for patient mix.

HCFA generated data indicated a total of 47 Medicare patients admitted to Navapache Hospital died within 30 days of admission. Of these, 32 died while still a patient, while 15 died after discharge.

While Navapache Hospital's mortality data does not reflect any diagnostic categories wherein the hospital's actual rate falls outside the predicted mortality rate, the placement within an actual range may be skewed by relevant factors not reflected in the ranges as described. Navapache Hospital, at that time, was a 35-bed facility in rural Arizona. With the small sample described, extremes at either end of the scale are favored.

The medical record does not contain information to verify the HCFA data on either the accuracy of post-discharge deaths or the diagnostic category assigned to a post-discharge death. Again, when dealing with the small sample representing Navapache Hospital, an error on even one case could misrepresent the hospital's position.

Navapache Hospital maintains a hospital-wide quality-assurance program. Each individual department or service determines those elements they will monitor to measure quality of care provided based on occurrence and industry standards. Mortality data is only one aspect of a many-faceted program.

Mortality data alone is insufficient to determine the quality of care provided at an institution. The medical record must be reviewed on a case-by-case basis before any conclusion may be made. Mortality data is raw data.

MVC/dj

NCCH

NORTHERN COCHISE COMMUNITY HOSPITAL, INC.

October 26, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, MD 21207

ATTN: William Roper, M.D.
Administrator

Dear Dr. Roper:

The data reported by HCFA for Northern Cochise Community Hospital indicates that a total of 130 cases were admitted to our facility with 20 of these patients expiring within 30 days of their admission (17 while still an inpatient and 3 after discharge). Our own records indicate that 217 Medicare admissions occurred in 1986; of these, 17 died as inpatients and reportedly an additional 3 expired after discharge from acute care. Presumably, the discrepancy reflects multiple admissions of individual beneficiaries to different hospitals. We have no way of verifying whether the 130 patients HCFA has reported as "last admissions" for NCCH are correct.

We feel that by utilizing only a portion of a specific group (i.e. 130 of a total 217 Medicare patients) to compile outcome statistics, the resulting percentages are not an accurate reflection of our hospital's actual mortality rate for that specific population. Per our records, the following chart reflects NCCH's 1986 patient activity for all Medicare patients utilizing the same ICD-CM codes HCFA has designated to determine each diagnostic category. You will note that, in addition to percentages, our report includes actual numbers for each category (both in-hospital deaths and those occurring after discharge).

MORTALITY NUMBERS

Cause	Total Cases	Mortalities/Death % In-Pts. /After	Mortality Statistic	Range of Predicted Mortality Rates
All	217	17/3	9%	5-18%
Cancer	6	2/0	33%	0-97%
CVA	9	5/0	55%	6-70%
GI	13	0/0	0%	0-30%
GU	3	0/1	33%	0-97%
GY	1	0/0	0%	0-100%
HL	29	0/0	0%	0-39%
HM	16	4/0	25%	5-61%
HS	9	2/0	22%	9-79%
ME	8	0/0	0%	0-23%
OP	14	0/0	0%	0-95%
PN	33	4/2	18%	5-40%

901 Rex Allen Drive, West • Willcox, Arizona 85643 • (602) 384-3541

Northern Cochise Community Hospital is an affiliate of Carondelet Health Services:
St. Mary's and St. Joseph's Hospitals & Health Centers, Southern Arizona's largest health care provider.

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

NCCH

NORTHERN COCHISE COMMUNITY HOSPITAL, INC.

Health Care Financing Administration

ATTN: William Roper, M.D.

October 26, 1987

Page 2

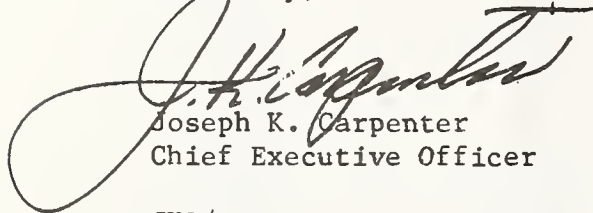
RN	3	0/0	0%	1-82%
TR	3	0/0	0%	0/92%
Other	70	0/0		

The patient data provided for the 17 in-patient mortalities occurring at Northern Cochise Community Hospital is correct. In 2 of the diagnostic categories listed by HCFA (CA & CVA), their statistics show that the hospital's mortality rate falls out of the range for "predicted mortality rates". Whether we use HCFA's figures or NCCH's figures for total admissions, it must be remembered that we are dealing with a very small sample which tends to favor extremes at both ends of the scale. It should be noted, however, that all of the cases from these 2 categories were reviewed by an outside, consulting physician in order to determine the quality and appropriateness of the patient's care. No problems were found with any of these mortalities.

Since the hospital's medical record does not include information occurring after discharge, we have no way of verifying the accuracy of HCFA statistics for those patients who expired after discharge.

In closing, we feel that statistical reports such as HCFA has proposed for publication cannot be the sole basis for judging quality of care; these reports can be very misleading without recognition of such factors as severity of illness, hospital size and location, and the lack of skilled nursing beds to accomodate potentially terminal patients.

Sincerely,



Joseph K. Carpenter
Chief Executive Officer

JKC/mm

cc: Medical Records

901 Rex Allen Drive, West • Willcox, Arizona 85643 • (602) 384-3541

Northern Cochise Community Hospital is an affiliate of Carondelet Health Services
St. Mary's and St. Joseph's Hospitals & Health Centers, Southern Arizona's largest health care provider

HCA Northwest
Hospital

October 12, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

RE: HCFA's Mortality Statistical Release

FROM: Northwest Hospital
ID# 030085

Dear Dr. Roper:

Overall, the mortality statistics for Northwest Hospital are within the predicted range for mortality rates. However, there are some concerns regarding the release of the data to the general public that should be addressed.

Publishing cold statistics will result in misinterpretation of the data and poor judgement being used to evaluate hospital performance and the quality of care rendered.

In order for the general public to have a fair chance with the interpretation and evaluation of this data, the following factors should be taken into consideration:

1. The methodology used to calculate the rates should be explained in a language that everyone can understand.
2. An explanation as to how to interpret the data should be given, such as why some hospitals have higher rates due to the condition of the patient upon arrival, the impact that the length of stay has, and how the number of patients treated in a specific category may impact outcome.
3. A statement explaining that only Medicare patients are represented in this study should be made.
4. An explanation regarding severity of illness should be made and why it was not taken into account when developing this data.

As you know, the outcome of an illness is affected by a variety of circumstances, many that have nothing to do with the care the patient received during the hospitalization, this is especially true if the patient expires after discharge. Since you are using these figures the general public needs to have more information regarding this.

Lack of providing the public with enough information to evaluate the hospital and the use of data from Medicare claims submitted to develop these statistics lends itself not only to misinterpretation, but opens the door for the public to suspect the hospital of poor patient care when in fact, this is not the case.

Thank you for the opportunity to share the hospital thoughts and concerns regarding this release.

Sincerely,

A handwritten signature in black ink, appearing to read "R. John Harris", written over a circular stamp or seal.

R. John Harris
Chief Executive Officer

cc: Patient Care Evaluation Committee

PAGE HOSPITAL

NORTH NAVAJO AND VISTA/P.O. BOX 1447/PAGE, ARIZONA 86040/(602) 645-2424

COMMENTS ON THE HCFA MORTALITY DATA

PAGE HOSPITAL

PAGE, ARIZONA

03-0047

The data used by HCFA indicate that a total of seven Medicare patients admitted to Page Hospital in 1986 died within 30 days of admission. Of these, six died while still a patient of the hospital, with one death occurring after discharge. Our own records indicate that 116 Medicare admissions occurred during 1986 as compared to the HCFA data of 70. Presumably, the discrepancy reflects multiple admissions of individual beneficiaries to Page Hospital.

Four of the seven deaths occurred in high risk categories in which death was a possible expected outcome given the nature and severity of the illness, complications, comorbidity conditions and other patient factors. Two deaths were contributed to chronic degenerative diseases in which death was once again an expected outcome.

In only one of the diagnostic categories was the hospital's actual mortality rate outside of the predicted range. In this particular category the hospital's mortality rate exceeded the expected rate by only one percent. In a small, rural community hospital the mortality rates are sometimes misrepresented by the relatively low number of Medicare admissions within a diagnostic category. Under these circumstances one death within a particular diagnostic category may greatly skew the mortality rates.

It is important to note the essential role that a sole community provider in an area such as Page, with no long term care or nursing home beds, plays in providing resources and services to the terminally and chronically ill. Without these options, there are times when a patient will be admitted in order to die.

There is one data error with regard to patient number [REDACTED]. The actual date of death is 3-7-86 as opposed to the HCFA date of 3-6-86.

Respectfully submitted,



Kevin P. Poorten
Administrator

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.



October 28, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Sirs:

While the current HCFA mortality data are helpful to hospitals and consumers as a way to indentify areas for further evaluation, they should not be used as an absolute measure of quality. The time period being studied is still too short to show consistent trends. The lack of an acceptable method for measuring severity of illness and other comorbidities also hampers this effort. The still unknown reliability of the model that HCFA used to construct these data is of major concern. Finally, until the HCFA model is validated, quality judgments can be made only on the basis of a case-by-case review of each patient's medical record.

Sincerely,

A handwritten signature in cursive script that reads 'William Coe'.

William Coe
Administrator

WC/rm

PHOENIX BAPTIST HOSPITAL AND MEDICAL CENTER

6025 North 20th Avenue / Phoenix, Arizona 85015 / (602) 249-0212



October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD. 21207

Re: Medicare Provider Number 030030

Dear Sir:

Our internal quality assurance program monitors and evaluates all deaths that occur within our facility. Our policy is to review not only Medicare deaths, but all deaths. Therefore, our Medical Staff and our Hospital Board have an ongoing awareness of our mortality as well as morbidity in that our criteria for quality assurance review encompasses both areas. Providing quality patient care is our number one goal.

Our actual mortality rate in all 17 categories was within the predicted range. We did verify the patients and dates of admission and discharge and found a few minor errors. For those patients who apparently died after leaving our facility, we are unable to determine if their cause of death was even related to their hospitalization. Thus we cannot validate this portion of the HCFA release.

As per your comment in your letter to our hospital administrator, we agree this information that will be released for HCFA is not a total measure of the quality of care provided at an individual hospital. In accordance with your letter, we also believe this information on hospital mortality rates is useful; however, until you have developed additional statistical measures to deal with complex issues such as severity of illness, we cannot and do not recommend the use of the information by itself to make judgment about the quality of care in an individual hospital or to make comparisons among hospitals.

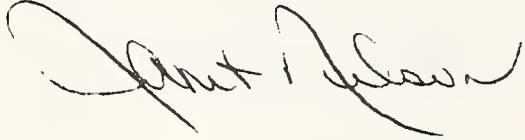
Prior to public release, it would be beneficial if HCFA would continue to refine the analytic methodologies and data validation techniques and develop and perfect other measures of quality that could compliment the individual hospitals internal QA process.

While the current HCFA mortality data are helpful to hospitals and consumers as a way to identify areas for further evaluation, they should not be used as an absolute measure of quality.

Page 2

The time period being studied is still too short to show consistent trends. The still unknown reliability of the model that HCFA used to construct this data is of major concern. THEREFORE, IN CLOSING, UNTIL THE HCFA MODEL IS VALIDATED, QUALITY JUDGMENTS CAN BE MADE ONLY ON THE BASIS OF A CASE-BY-CASE REVIEW OF EACH PATIENT'S MEDICAL RECORDS.

Sincerely,

A handwritten signature in dark ink, appearing to read "Janet Nelson", written in a cursive style.

Janet Nelson, R. N.
A. V. P. Administrative Services

/bn

Phoenix General Hospital

Non Profit Osteopathic

1950 West Indian School Road
P. O. Box 21351
Phoenix, Arizona 85056
(602) 279-4411

October 22, 1987

COMMENTS FOR PUBLICATION WITH THE 1986 HCFA MORTALITY DATA FROM MEDICARE PROVIDER NUMBER 030020

The diligent efforts preceding this second annual release, as well as the release itself, serve as a good take-off point in the further development of more meaningful measures of quality.

We are pleased to note in Dr. Roper's letter of September 21, 1987 that, "...HCFA will make clear that the information on its own is not a complete measure of the quality of care at an individual hospital."

It will be the natural inclination of the public to equate mortality to quality of care. It is imperative therefore, that HCFA initiate a significant public education program to reinforce Dr. Roper's additional statement that, "...we can not and do not recommend the use of the information by itself to make judgements about the quality of care in an individual hospital or to make comparisons among hospitals."

It is hoped that the combined efforts of government and healthcare providers will lead to a greater understanding of the variables, (ie. severity of illness), in the empirical formula for a meaningful measure of quality.

The quest for quality of care and quality of life is an inherent, fundamental pursuit of the mission of our institution, which primarily is the delivery of osteopathic medical care and to provide the most comprehensive osteopathic medical education programs for externs, interns and residents from throughout the country.

Better measures would supplement the continuous process of utilization review and quality assurance procedures in our institution, and further add to those factors regularly reviewed to assure the delivery of quality services.

Additionally, they would bolster the monitoring of, and strive for constantly improving standards of healthcare by both consumers and providers.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Health Resources and
Services Administration
Indian Health Service

DHHS — Indian Health Service
IHS Indian Hospital
P.O. Box 860
Whiteriver, AZ 85941-0860
(602) 338-4911

October 26, 1987

Arizona Hospital Association
Attention: HCFA
2411 West 14th Street, Ste. 410
Tempe, Arizona 85281-6943

Dear HCFA:

It was with interest that I reviewed your recently received mortality data for the Whiteriver Indian Health Service Hospital.

A number of comments are in order. First in regards to the actual two mortality cases (see Attachment A):

- A. Case [REDACTED] -
 - 1. The actual date of death was 05/25/86 in our hospital, not 05/31/86 post discharge as listed,
 - 2. Due to our coding error the principal diagnosis should actually be 197.7 or metastatic carcinoma of the liver, unknown primary,
 - 3. Patient ID number should read [REDACTED] as patient was covered under her husband's social security benefits:
- B. Case [REDACTED] - Again due to our coding error the principle diagnoses should be 156.1 or cholangiocarcinoma:
- C. Both of these cases were end stage cancer cases and patients were admitted to our facility at patient and family request for hospice like service including "do not resuscitate" orders. As an Indian Health Service Facility our patients do not readily have available these services other than from us. However long term this could adversely affect our mortality statistics, if it is not noted that we are supplying these services.

Additional general comments and concerns regarding the process include:

- A) In a smaller facility such as ours with small sample groups it would be potentially easy to fall out of predicted mortality rates with just a one case sample size and resultant 100% mortality under a category.
- B) There is concern about the apparent lumping of all cancer cases together. If one has two deaths from a potentially curable cancer (e.g. breast) this would be of far more significant than say from pancreatic cancer. But these important differences would not be showing up in the statistics.

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

In summary, we appreciate the importance of establishing consistent mortality data, including important quality assurance implications, and look forward to working with you in developing a system that accurately reflects the unique characteristics of each facility.

Yours truly,

A handwritten signature in black ink, appearing to read 'R. Caldwell', with a long horizontal flourish extending to the right.

Richard T. Caldwell, M.D.
Clinical Director, WRSU

DIAGNOSTIC CATEGORY	CASES	ACTUAL MORTALITY RATE	RANGE OF PREDICTED MORTALITY RATES
ALL CAUSES	26	12 %	3 TO 29 %
CE - CEREBROVASCULAR ACCIDENTS	2	0 %	1 TO 89 %
GI - GASTROINTESTINAL DISEASE	6	0 %	0 TO 63 %
GU - UROLOGIC DISEASE	1	0 %	0 TO 100 %
HL - LOW-RISK HEART DISEASE	2	0 %	0 TO 100 %
HM - SEVERE CHRONIC HEART DISEASE	1	0 %	0 TO 98 %
HS - SEVERE ACUTE HEART DISEASE	1	0 %	1 TO 97 %
ME - METABOLIC/ELECTROLYTE DISTURBANCES	1	100 %	0 TO 97 %
PN - PULMONARY DISEASE	1	0 %	0 TO 98 %
RN - RENAL DISEASE	1	0 %	0 TO 100 %
SE - SEPSIS	1	100 %	1 TO 97 %

Comments

Please note that the numbers are small, and thus not as reliable as they could have been
 => Not an accurate reflection of the care administered at our hospital

E. Castro MD

E. CASTRO

Clinical Director

10/1/87

PHOENIX INDIAN MEDICAL CENTER

RESPONSE TO HCFA SELECTED MORTALITY INFORMATION

DATA VERIFICATION

In late September, the Phoenix Indian Medical Center (PIMC) received selected Medicare Mortality data from the Health Care Financing Administration (HCFA). HCFA Mortality Data indicated that during 1986, there were one hundred and sixty-seven (167) Medicare patients admitted to PIMC. Of those 167 patients, eighteen (18) died within thirty (30) days of admission.

Upon review of the record of those 18 cases, the following corrections were made. One date of death was corrected to show that death occurred while the patient was still at PIMC and not after discharge.

The second correction involved an error in coding the principle reason for admission. With accurate coding, one case was removed from the Renal Disease category.

The corrected statistics show that seventeen (17) of the deaths occurred at PIMC with the one (1) remaining death occurring at a nursing home.

The only category corrected was Renal Disease. The correct number is one (1) case.

CASE MIX CHARACTERISTICS

Review of the HCFA mortality data pointed out the need for thorough case-by-case peer review prior to making any quality of patient care judgments. PIMC is in agreement with the American Hospital Association's statement that "Quality can only be evaluated through peer review - not through simple statistical comparisons." The physician Chairperson of the PIMC Patient Care Evaluation Committee undertook a second mortality review of the 18 cases. A second review in that mortality case review has long been an ongoing physician peer review Quality Assurance program at PIMC.

The Phoenix Indian Medical Center is a referral center for outlying small rural Indian hospitals and clinics. In addition, PIMC serves as an urban community hospital with residency training programs in obstetrics, general surgery, ophthalmology and family practice.

The 18 patients included in the HCFA study had the following characteristics in common. Three (3) of the patients were accepted in transfer from other acute care facilities. Seven (7) of the patients were receiving long term care through a nursing home or hospice care program. Fourteen (14) or over three-fourths of the cases, involved a patient's request that no extraordinary measures be taken to prolong life.

The medical problems common to this group of 18 patients included insulin dependent diabetic mellitus, renal failure, chronic coronary artery disease, and respiratory failure.

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

INTERPRETIVE REMARKS

Using the HCFA data to identify areas for review, particular attention was given to the one category, Renal Disease, where the Phoenix Indian Medical Center's actual mortality rate fell out of the HCFA predicted range. There were two cases assigned by HCFA to this category. After physician review, it was determined that one of the two cases had been incorrectly assigned to the Renal Disease category. That left the Renal Disease category with one case - one death - 100% mortality rate. Given the extremely small sample size of one patient, statistical conclusions are impossible.

Physician review of the one remaining Renal Disease category case brings into focus the severity of illness factor lacking in the HCFA model. PIMC's one renal disease case was an 87 year old nursing home resident suffering from chronic renal failure. On admission, the patient was placed on the seriously ill list, and by patient request, an order was written limiting the use of extraordinary life prolonging measures.

Again using the HCFA data to identify areas for possible review, PIMC looked closely at the deaths listed by HCFA in the low risk categories.

PIMC had one case assigned to the "low risk" category of Orthopedic Conditions. Physician review did show that the case was properly classified with the admitting diagnosis of fractured right femur. What is not taken into account with the HCFA model are the additional medical problems relating to the death of this 78 year old patient, i.e. metastatic adenocarcinoma of the prostate, coronary artery disease, history of myocardial infarction, left bundle branch heart block and insulin dependent diabetes mellitus.

The second case assigned to the "low risk" category of Gastrointestinal Disease was a case of chronic alcohol abuse and advanced liver disease with uncontrollable gastrointestinal bleeding and death.

In summary, peer review showed in both the Renal Disease category and the two "low risk" categories that consideration of severity of illness and expected death in cases of terminal disease is crucial to any mortality review model.

GENERAL STATEMENT

The Phoenix Indian Medical Center will continue to seek excellence in patient care. Toward that end, the hospital's Governing Board, quality assurance program, and medical staff have and will continue to work together to take advantage of every possible opportunity to improve patient care.



SCOTTSDALE
MEMORIAL
HOSPITAL

October 27, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Data
P.O. Box 26684
Baltimore, MD 21207

Attention: Harvey Brooks

Dear Mr. Brooks:

This letter is written in anticipation of the proposed December, 1987 release of mortality data by the Health Care Financing Administration. We appreciate the opportunity to communicate our comments and concerns to you. We feel very strongly that the data should not be released until it can be refined to a point where it is useful to consumers and health care professionals alike in evaluating the performance of the hospital.

Scottsdale Memorial Health Systems is a private not-for-profit corporation which operates two general acute-care hospitals: Scottsdale Memorial Hospital-Osborn and Scottsdale Memorial Hospital-North. We are designated as a Level I Trauma Center, we provide many tertiary level services such as open heart surgery, laser angioplasty, and magnetic resonance imaging, and we sponsor an accredited Residency Program in Family Practice. We are accredited by the Joint Commission on Accreditation of Healthcare Organizations and as such, have developed a very effective quality assurance program which includes the review of all deaths in the hospital by the appropriate medical staff department (Medicine, Surgery, Pediatrics, etc.).

We have reviewed our mortality rates in the sixteen categories and compared them to the predicted range. Both our hospitals are well within the ranges in all sixteen categories. The following comments relate to the utility of this information for evaluating the performance of a hospital.

We agree conceptually with the provision of useful information to Medicare beneficiaries so that they can become better informed

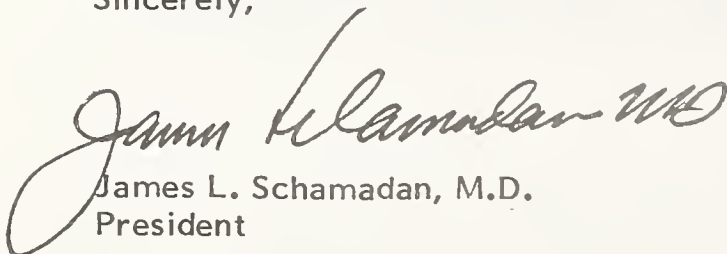
consumers. However, the mortality data, as presented, do not constitute valid and reliable measures of hospital performance. Even statements contained in the Federal Register and correspondence from Dr. Roper suggest the data to be inadequate for evaluating hospital performance. In the August 17th, 1987 Federal Register, the mortality rate information was supposed to be used "...for consumers in making decisions in obtaining health care". In Dr. Roper's letter dated September 21st, 1987 to Hospital Administrators, the statement is made "We cannot and do not recommend the use of the information by itself to make judgements about the quality of care in an individual hospital or to make comparisons among hospitals". If the data cannot be used to make judgements about quality then how will it be useful to consumers in making choices? There are legitimate questions as to whether or not mortality rates are a valid and reliable measure of quality even for peer review purposes. If accepted predicted ranges do not include all of the important factors which affect mortality (e.g. severity of illness) then the mortality rates are not useful as measurements of quality. Until better measures of severity are developed which incorporate the significant factors affecting mortality into the predicted ranges, it is not possible to draw conclusions about quality from mortality rates.

In the August 17th, 1987 Federal Register, it was pointed out that HCFA solicited input from experts in health care professions in developing their statistical model and strategies for this release of information. However, it is significant to us that you have received letters from the American Medical Association, American Hospital Association, CPHA, and JCAH, each voicing objections and/or concerns over this release of data. We concur that these concerns are valid and would lend our support to the position taken by these organizations.

In summary, we believe that the release of mortality data in its current form will be at best confusing, and at worst harmful, to consumers and health care institutions across the country. If, despite all of the above, this data is released, we strongly support the recommendation of Dr. James H. Sammons, Executive Director of the American Medical Association, in his letter to Dr. Roper dated September 10, 1987 that a statement be included in the released document which makes it clear that "the data does not measure quality and may not, as to any particular hospital, be a valid measure of hospital performance".

Thank you for giving us the opportunity to offer our opinion.

Sincerely,


James L. Schamadan, M.D.
President

/ka

SCOTTSDALE
MEMORIAL
HOSPITAL

October 27, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Data
P.O. Box 26684
Baltimore, MD 21207

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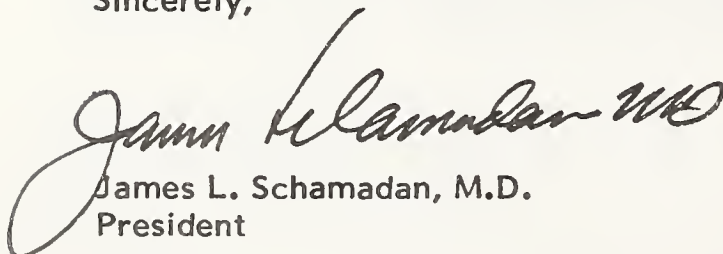
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In summary, we believe that the release of mortality data in its current form will be at best confusing, and at worst harmful, to consumers and health care institutions across the country. If, despite all of the above, this data is released, we strongly support the recommendation of Dr. James H. Sammons, Executive Director of the American Medical Association, in his letter to Dr. Roper dated September 10, 1987 that a statement be included in the released document which makes it clear that "the data does not measure quality and may not, as to any particular hospital, be a valid measure of hospital performance".

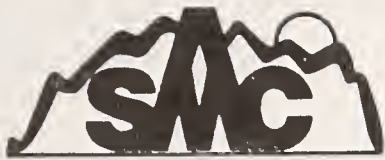
Thank you for giving us the opportunity to offer our opinion.

Sincerely,



James L. Schamadan, M.D.
President

/ka



SOUTHEAST ARIZONA MEDICAL CENTER

October 19, 1987

RURAL ROUTE 1 — BOX 30 — TELEPHONE 602/364-7931
DOUGLAS, ARIZONA 85607

William L. Roper, M.D.
Health Care Financial Administration
Washington, D.C. 20201

Dear Dr. Roper,

Thank you for this opportunity to respond to the release of data on hospital mortality rates for the year of 1986. Southeast Arizona Medical Center is a healthcare facility licensed for seventy-nine (79) acute care beds and forty-three (43) long term care beds which is located in the southeastern part of Arizona. Our case mix includes many patients with major medical and surgical illnesses.

At this hospital, mortality review is an ongoing process of the quality assurance program and our peer review activities are conducted monthly in the medical and surgical staff committee meetings. An intensive review of the charts of every patient who expires at this facility is conducted by members of our medical staff in conjunction with administration and appropriate nursing personnel.

During the mortality chart review the overall plan of care is scrutinized by our medical staff and any questions regarding the medical management of the patient are directed to the attending physician. Through this mechanism we feel we are addressing any quality problems which may arise immediately.

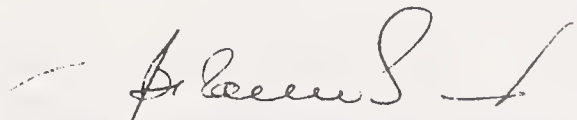
The mortality data for our hospital has been carefully reviewed by hospital administration, the chief of staff, and the physician advisor for the Professional Activities Committee and the Director of Quality Assurance.

Our monitoring systems provide a continuous feedback mechanism which meets and exceeds quality care standards, but we plan to continue refining our systems to provide the highest level of care to the citizens of our hospital service area.

Once again thank you for this opportunity to respond to this data.

Sincerely,


R. C. Benjamin, Administrator


Jose H. Romo, Chief-of-Staff



HOSPITAL AND
HEALTH CENTER

October 26, 1987

Administrator
HCFA
Department of Health & Human Services
Washington, D.C. 20201

ATTN: Medicare Mortality Statistics

Dear Sir or Madame:

The data used by HCFA indicate that a total of 312 Medicare patients admitted to St. Joseph's Hospital and Health Center in Tucson, Arizona, died within 30 days of admission. Of these, 292 died while still a patient of the hospital, while 70 died after discharge. Our own records indicate that 4,593 Medicare admissions occurred in 1986.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in the analysis.

In one of the diagnostic categories, cerebrovascular accidents, St. Joseph's actual mortality rate falls outside of the range of the predicted mortality rate. It must be emphasized that statistics by themselves do not reflect the condition on admission or the severity of the illness to be treated. Within the cerebrovascular category, 74% of the patients arrived via the emergency room; over half (63%) were in a severe comatose state from which they never regained consciousness, and 26% died within the first 24 hours after admission. Neurology consultation delivered prognosis that the patient would not survive for 30% of these patients, for which supportive care was then provided.

While St. Joseph's Hospital concurs that the HCFA mortality data are helpful to hospitals and consumers as a way to identify areas for further evaluation, we are adamant that the data, by itself, cannot be used as an absolute measure of quality. The time period being studied is still too short to show consistent trends, and the lack of an acceptable method for measuring severity of illness and other comorbidities also hampers this effort. The still unknown reliability of the model HCFA used to construct these data is of major concern. Finally, until the HCFA model is validated, quality judgments can be made only on the basis of a case-by-case review of each patient's medical record.

CHS / CARONDELET HEALTH SERVICES, INC.

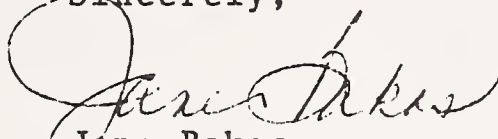
350 NORTH WILMOT ROAD / P.O. BOX 12069 / TUCSON, ARIZONA 85732
602/296-3211

Administrator, HCFA
Page Two of Two
October 26, 1987

We at St. Joseph's Hospital, Tucson, have worked with our medical staff to develop parameters to assess the quality of care provided and have established courses of action when patterns or trends identify problems to be corrected or opportunities to improve our care. Our confidential peer review process is systematic and ongoing involving the physician staff from the initial chart review to the consideration of quality assurance data in the credentialing/reappointment process.

Thank you.

Sincerely,

A handwritten signature in cursive script, appearing to read "Jane Bakos".

Jane Bakos
Vice President

350 West Thomas Road
Post Office Box 2071
Phoenix, Arizona 85001-2071
285-3000 (Area 602)

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

St. Joseph's Hospital and Medical Center is a 626 bed tertiary care facility including level I trauma, high-risk newborn, radiation oncology program and a graduate medical education program of over 120 positions.

At St. Joseph's Hospital and Medical Center we have an on-going, comprehensive, integrated Quality Assurance Program involving Medical Staff, Nursing and Professional Support Services. Clinical indicators (criteria), established by Medical Staff and Clinical Services, are used throughout the hospital to help measure clinical outcome against established standards of care.

Patient care review is accomplished monthly, within each clinical department where the results of on-going monitoring process are reviewed and evaluated for action, if necessary.

The St. Joseph's Quality Assurance Program was developed more than five years ago, and has always been supported by our Board of Directors and the Medical Executive Committee. Our governing body requires assurance of provision of one level of patient care in the hospital to all patients. They have also provided the resources to accomplish this and to report on activities and mechanisms which are in place for monitoring and evaluating the quality of care, for identifying and resolving problems and for identifying opportunities to improve patient care.

William L. Roper, M.D.
October 27, 1987
Page two

St. Joseph's Hospital and Medical Center is proud of the quality of care which we provide and our commitment to maintaining this quality care is a constant. We think the real issue in the release of hospital specific mortality rates is the way the data is used, its interpretation and accuracy. While we recognize that patients have a legitimate interest in obtaining useful, reliable information on the quality of care that is available to them, we think that mortality rates, by themselves, do not measure quality. Mortality data is appropriately used to guide or focus peer review, as quality can only be evaluated through the process of peer review. Further, because mortality data is easily misinterpreted, it can cause confusion and apprehension among Medicare beneficiaries and the public in general, and it is this improper interpretation or perception by the public which is of great consequence.

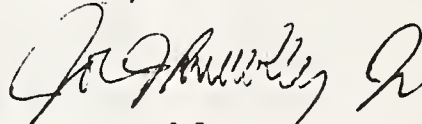
Our major concerns with the data are as follows:

- 1) they do not take into consideration the severity of illness. As a result, hospitals treating unusually large numbers of severely ill patients, or with specialized programs for the terminally ill, may have significantly higher than predicted mortality rates;
- 2) the accuracy of the discharge diagnostic coding and its presumption as cause of death.
- 3) it is not all-inclusive since the rates apply only to Medicare patients and differ from other indicators of inpatient mortality because they are calculated using only deaths that occur within 30 days of the last hospital admission of a Medicare beneficiary during 1986, regardless of whether or not the death is related to the hospitalization.
- 4) many of the disease diagnostic categories are not of sufficient size to be statistically valid.
- 5) the status of hospital as an urban tertiary facility vs. rural community hospital is not considered.
- 6) not having access to the statistical model used to obtain the raw data prior to its release.

William L. Roper, M.D.
October 27, 1987
Page three

We appreciate the opportunity to respond and can offer assurances that we continue to strive for excellence in patient care. We also continue to pursue methods of evaluating hospital quality that rely on objective measures other than mortality data which will be more accurate indices. We support these efforts because philosophically we believe that this is information the public needs to have.

Sincerely,

A handwritten signature in dark ink, appearing to read "John J. Buckley, Jr.", with a stylized flourish at the end.

John J. Buckley, Jr., FACHE
President

JJB:gs



COMMENTS ON THE HCFA MORTALITY DATA
Hospital ID Number 030037

DATA VERIFICATION

The data used by HCFA indicate that a total of 105 Medicare patients admitted to this hospital died within 30 days of admission. Of these, 81 died while still a patient of the hospital, 4 died while still a patient of the Skilled Nursing Facility (a separately licensed facility), while 20 died after discharge. Our own records indicate that 2853 Medicare admissions occurred in 1986 (this is based on fiscal year 86-87 data). We have no way of verifying whether HCFA's records of the total number of Medicare patients treated is correct. Therefore, there is potential for discrepancy due to multiple admissions of individual beneficiaries to different hospitals. Our own records also indicate that of the 105 Medicare patients who died within 30 days of admission, 20 were still alive at the time of discharge. After a patient is discharged it is impossible for the hospital to determine the cause or date of death, as information concerning death after discharge is not included in the patient's medical record.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

INTERPRETIVE REMARKS

Because medical record coding is not an exact science, interpretation allows for identification of expected and unexpected complications. Better documentation by the medical staff has resulted in additional diagnosis being entered on the claims forms.

UNIQUE SERVICES

Our medical center has historically treated patients experiencing multiple system disease, complicated by stringent socioeconomic factors. The acceptance of transfers from facilities not performing complex cardiac surgery, including medical and surgical intervention for ventricular arrhythmias, increases the potential incidence of morbidity and mortality; however, our actual mortality rates fell within the range of predicted mortality rates in all three categories of heart disease.

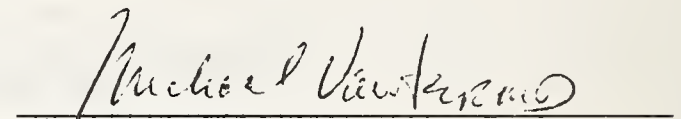
Our hospital Medical Staff and Administration has not only maintained, but encouraged close scrutiny of the quality of care provided to their patients. Thus, the medical center has enjoyed full accreditation by JCAH with praise for its Quality Assurance program. In addition, intensified review by Health Services Advisory Group (HSAG) (The Peer Review Group of Arizona) for quality of care issues has never been necessary or instituted.

Page -2-

We welcome discussion not only about these statistics, but invite comments from the media and public regarding their needs to better understand the treatment provided. The Medical Staff and Administration mutually support quality patient care and the review inherent to assuring that care.

Respectfully,


Mary Starmann-Harrison
Administrator


Michael Vawter, M.D.
President, Medical Staff

MSH:MV:fad



HOSPITAL AND
HEALTH CENTER

October 23, 1987

Administrator
HCFA
Department of Health and Human Resources
Washington, DC 20201

ATTENTION: MEDICARE MORTALITY STATISTICS

Data Verification

The data used by HCFA indicate that a total of 400 Medicare patients admitted to St. Mary's Hospital died within 30 days of admission. Of these, 310 died while still a patient of the hospital, while 90 died after discharge. Our own records indicate that 6,662 Medicare admissions occurred in 1986.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

Interpretive Remarks

The hospital's actual mortality rate does not fall outside of the range of the predicted mortality rate for any of the diagnostic categories.

General Comments

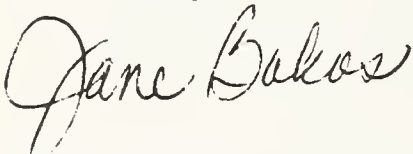
While the current HCFA mortality data are helpful to hospitals and consumers as a way to identify areas for further evaluation, they should not be used as an absolute measure of quality. The time period being studied is still too short to show consistent trends. The lack of an acceptable method for measuring severity of illness and other comorbidities also hampers this effort. The still unknown reliability of the model that HCFA used to construct these data is of major concern. Finally, until the HCFA model is validated, quality judgments can be made only on the basis of a case-by-case review of each patient's medical record.

HCFA
October 23, 1987
Page 2

We wish to point out that in reviewing the information HCFA provided, we found that several of the patients were terminal and that the family requested no heroic life saving measures to be taken; one patient was a terminal lung cancer patient and was grouped in the low risk heart disease group. St. Mary's also has a hospice unit, and we expect an increased number of deaths to be reflected because of that.

St. Mary's Hospital, its staff and physicians are actively involved in a quality assurance program, which reviews patient mortality and morbidity. We believe that we monitor adverse patient outcomes and identify and address any clinical problems in a timely and proactive manner.

Sincerely,

A handwritten signature in cursive script that reads "Jane Bakos". The signature is written in dark ink and is positioned above the printed name and title.

Jane Bakos
Vice President

JB/ch

Thunderbird Samaritan
Hospital and Health Center



October 26, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

Re: HCFA Mortality Data for Thunderbird Samaritan Hospital and Health Center
(Hospital #030089)

Dear Dr. Roper and Health Care Consumers:

Thank you for the opportunity to respond to the release of data regarding mortality rates of Medicare patients treated at Thunderbird Samaritan Hospital and Health Center during 1986.

The data used by HCFA indicate a total of 1,622 Medicare patients were admitted to Thunderbird Samaritan Hospital during 1986 and that 202 of these patients died within 30 days of admission. It may be noted that 29 of those 202 patients died after being discharged from the hospital.

In order to ensure patient confidentiality, a separate letter addresses case-specific discrepancies we found after reviewing these charts and provides corrected data.

Thunderbird Samaritan Hospital and Health Center medical staff committees monitor patient care in this facility on an ongoing basis in an effort to meet quality of care standards. We appreciate the opportunity to present this response and if you or anyone receiving this information has questions about the data or our response, please do not hesitate to contact me.

Sincerely,

A handwritten signature in dark ink, appearing to read 'Charles H. Welliver'. The signature is fluid and cursive, with a prominent initial 'C'.

Charles H. Welliver, FACHE
Vice-President/Chief Executive Officer

lm



October 23, 1987

Office of the President

William L. Roper, MD
Health Care Financing Administration
Department of Health and Human Services
Post Office Box 26684
Baltimore, Maryland 21207

Dear Doctor Roper:

Tucson Medical Center (Medicare Provider Number 030006) has received your mailing of September 21, 1987 which included data on the experience of Medicare beneficiaries at this institution. We appreciate the opportunity to comment upon these data and submit the following remarks.

Tucson Medical Center, a 615-bed general hospital, is the largest hospital in Southern Arizona. It serves as a regional referral center for southern Arizona, western New Mexico, and northern Mexico. The hospital has active programs in Trauma, Cancer Treatment, Cardiology, Cardiac Surgery, Vascular Surgery, Neurology, Neurosurgery, Obstetrics, Gynecology, Pediatrics, Orthopedic Surgery, Urologic Surgery and Rehabilitation, as well as General Medicine and Surgery.

We find no significant errors of fact with the material presented to us by the Health Care Financing Administration. It should be noted that over 25% of the deaths attributed to the hospital in this data occurred after the patient was discharged. It is very difficult to determine what relationship, if any, existed between the care provided to the patient in this setting and the ultimate cause of death.

Tucson Medical Center has a long standing commitment to patient education and information and applauds any effort to provide consumers with information to make better health care choices. We are concerned, however, in the absence of a commonly accepted measure of severity of illness presentation of mortality data alone may cause inappropriate inferences to be drawn. With only the information available here, it would be incorrect to make any assumptions regarding the quality of care delivered by any institution. The best source of health information continues to

5301 EAST GRANT ROAD • BOX 42195 • PHONE (602) 327-5461 • TUCSON, ARIZONA 85733

William L. Roper, MD
October 23, 1987
Page Two

be each patient's personal physician who is most aware of each individual's unique circumstances and of the resources available in each community.

The methodology utilized by the Health Care Financing Administration to predict the mortality rates is unclear and untested. Such methodologies should be open to critical review and study prior to their application in documents to be released to the public. Although the Health Care Financing Administration has stated the detail of their statistical model would be made available, requests for that information have not been fruitful.

Mortality studies are but one component of a meaningful review of a patient's care. In the context of the coordinated quality assurance program at Tucson Medical Center, every death is reviewed by a panel of physicians and other health professionals. The information from these analyses is integrated with information from study of other aspects of patient care. This coordinated approach allows us to continually improve the quality and acceptability of the care we render to our patients.

Sincerely,



Richard Polheber
Senior Vice President and
Chief Operating Officer



University Medical Center

1501 North Campbell Avenue
Tucson, Arizona 85724

Administration
(602) 626-6501

October 28, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health & Human Services

Dear Dr. Roper:

On behalf of University Medical Center, I submit the following comments concerning the generation and dissemination of Medicare Mortality data. In general, information that tends to influence the provision of the highest quality of medical care is well worthwhile and supported not just by University Medical Center but by the industry as a whole. We all have a responsibility to continually strive to meet the needs of our patients in as an effective and efficient manner as possible. In light of this, the following comments are provided:

DATA BASE

The basic utilization data HCFA used for University Medical Center appears to be reasonably accurate. HCFA's data base concerning admissions and deaths while hospitalized is consistent with our records. We are not able to verify deaths nor the cause of deaths within thirty days of admission and after discharge, so the reliability of this information is not determinable. Therefore, we have some general concern over the overall reliability of the calculated mortality rates.

STUDY ANALYSIS

HCFA should be complimented on the attempt to develop a statistical model to address basic mortality data. Any study is bound to have limitations. It is these inherent limitations that are problematic especially on data that will be so widely disseminated. In general, it is reasonable that mortality rates falling above the prediction interval would warrant further review and explanation for such a disparity. However it is unclear whether rates within or even below the predicative range are reliably informative.

Dr. William L. Roper
October 28, 1987
Page Two

We feel there are a number of limits to the HCFA analysis of the data. A summary of these limitations are:

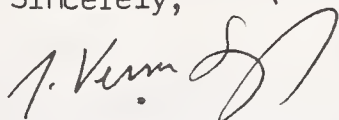
- No severity or acuity index is available to prognostically develop mortality expectations.
- Significant factors that contribute to mortality rates are not part of the HCFA data base. This lack of data could artificially increase or decrease mortality prediction intervals.
- There is no information available as to individual hospital rates being biased.
- Transfer patterns between hospitals can greatly distort mortality rates as well as predictive intervals. Not having information on how this affects the rates, the results may be biased.
- All institutions could do a better job of interpreting the data if a detailed description of the statistical model were available.

MORTALITY RATES

Even though University Medical Center's mortality rates all fall well within HCFA's predictive ranges, we have some inherent concern over the use and interpretation of the data. There will be an unavoidable comparison of individual hospital rates even though the model is not designed nor intended for this purpose. Individual patient outcome does not readily fall into a predictive model. A careful and coordinated approach on the release of this data is essential if inappropriate inferences are to be avoided.

If there is any way we can be of further assistance, please do not hesitate to let me know.

Sincerely,



J. Verne Singleton
Chief Operating Officer

JVS:ls

cc: Louis J. Kettel, M.D., Dean, College of Medicine
John Puhala, Chief Executive Officer
George Ray, M.D., Chief of Staff
William C. Scott, M.D., Medical Director

FILE: HCFA-Mortality Rates
1505V



Valley Lutheran Hospital

6644 Baywood Avenue
Mesa, AZ 85206
602-981-2000

M E M O R A N D U M

TO: Department of Health and Human Services
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

FROM: Charles R. Brackney, Administrator
Valley Lutheran Hospital

Claytona Stockdale, Director, Utilization Management
Lutheran Healthcare Network

RE: Valley Lutheran Hospital
HCFA Mortality Data

DATE: October 22, 1987

This memo is in response to the release of mortality data which is relevant only to Valley Lutheran Hospital. After receiving the data which is inclusive of Medicare patients whose last admission was to our hospital and who died within 30 days of that admission, we researched and made the foregoing conclusions.

DATA VERIFICATION

The data submitted by HCFA indicates a total of 2,582 Medicare patients were admitted to our hospital. Our records indicate that 3,543 Medicare admissions occurred in 1986. It is our feeling, the discrepancies between HCFA's "All Causes-2,582" and our Medicare admissions of 3,543 reflects multiple admissions of individual beneficiaries.

The HCFA data indicates a total of 308 Medicare patients admitted to Valley Lutheran Hospital died within 30 days of admission. We verified this figure and found although the admission dates of a few were incorrect, the total was correct. Of these 308 patients, we verified that 258 died within their respective hospital stay. In 3 cases, the patients died at a neighboring hospital. Of the 308 patients, 50 died after discharge.



Valley Lutheran Hospital

6644 Baywood Avenue
Mesa, AZ 85206
602-981-2000

We were able to verify, with the assistance of physicians and local hospitals, the deaths of 50 out of 50 patients who expired outside of this institution. After extensive research, we found that 29 were sent home designated as "No Code" status, 4 were sent home refusing further treatment, and arriving later in the ER DOA, 4 others died in our ER in "code status", 11 were disease related, 1 suicide and 1 motor vehicle. Appropriate discharge planning was documented on each of these discharges. 46% were discharged to extended care facilities or long term care facilities.

Due to the extensive man hours and subsequent cost to research and validate each of these 308 patients, we selected to verify the data based on 5 of the data variables, utilizing a sample size of 100 patients. We found the following inaccuracies:

of Errors

Sex:	1
Date of Death:	5
Date of Admission:	2
Date of Discharge:	2
Principle Diagnosis:	9

The errors for principle diagnosis fell into the categories of Gastrointestinal Catastrophe (GC), Gastrointestinal Disease (GS), Severe Chronic Heart Disease (HM), Low Risk Heart Disease (HL), Pulmonary (PM), Sepsis (SE), and Other Disorder (UN). These nine cases would minimally alter our mortality percentages.

Since our organization (Lutheran Healthcare Network) endorses the MEDISGRPS Severity of Illness Index, we decided to correlate the sample cases (100) with the corresponding Severity of Illness Index. As you know, MEDISGRPS is based on "key clinical findings" which places a patient's disease process into a severity of illness range between 0-4. Zero severity means patients admitted for symptoms with no objective findings or elective procedures. One severity means patients with a few abnormal findings and the likelihood of going into organ failure is remote. Two severity means patient with significant findings who may go into organ failure in the immediate future. Three severity means patients with severe findings who are in single organ failure. Four severity means patients with critical findings indicating the presence of multi-system organ failure.



Valley Lutheran Hospital

6644 Baywood Avenue
Mesa, AZ 85206
602-981-2000

Our severity of illness verified that these 100 patients fell into the range greater than 1 and less than 4 with an average of 2.85. Of the 50 patients discharged, their average severity of illness was 2.62. Thus, patients who expired in-house had documented clinical findings which could have and did result in death. The discharged patients, based on MEDISGRPS, also had the potential for mortality.

INTERPRETIVE REMARKS

Valley Lutheran Hospital does not fall outside the predicted mortality rate in any category.

In our investigations, we discovered information that could effect the overall picture for any hospital's mortality rate. First, sex, diagnosis, and date of death were found to be incorrect within our sample. These factors could easily alter the mortality percentage. We found a severity of illness factor useful in validating the extent of illness. We discovered patients who died in other facilities. In this case, we wondered, did both hospitals receive credit for the death? Or, was it the hospital that submitted the first bill? We found causes not related to illness, such as a motor vehicle accident. We found that patients do refuse further treatment. Finally, we found physicians to be very helpful in our efforts.

As a final point of interest, we did investigate those categories which appeared to be at the high point of the predicted range. Severe Acute Heart Disease was, for us, the most obvious. Once again, we researched each chart and verified the severity of illness at 2.86. We also investigated Stroke and Trauma. The severity of illness for stroke was 2.69 and trauma, 3.9.

In closing, we would like to note that Valley Lutheran Hospital has a Quality Assurance program that is systematic, planned and ongoing which reviews case-by-case each hospital death, as well as, other key factors to protect our patients from negative outcomes. Our Quality Assurance model also provides a mechanism to improve the quality of care rendered.

Thank you for the chance to address this issue.

Sincerely,

CL R. Brackney

Charles R. Brackney
Administrator

VALLEY VIEW COMMUNITY HOSPITAL

12207 North 113th Avenue / Youngtown, Arizona 85363 / (602) 933-0155



October 27, 1987

Medicare Provider #03-0057

William L. Roper, M.D.
Administrator
Department of Health and
Human Services
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for this opportunity to respond to the HCFA Mortality Data.

In none of the diagnostic categories, the hospital's actual mortality rate falls outside of the range of the predicted mortality rate. Over 80% of the discharged patients are Medicare and this is one of the highest Medicare populations in the nation. Forty-eight of the 117 Medicare patients admitted to Valley View Community Hospital who died within 30 days of admission were over the age of eighty or 41%. The age of our Medicare patients has a direct impact on the mortality rates with the diagnosis in the upper quartile.

Valley View Community Hospital is a 104 general acute care facility. Because of our location, the present focus is on geriatrics. Besides the medical and surgical area, we offer an indepth geriatric human development program for severe depression, a detoxification unit for the elderly plus an extensive health education program for the communities we serve.

Sincerely,

Duane R. Vorseth,
Vice President and Administrator

Walter O. Boswell Memorial Hospital, Inc.

Post Office Box 1690
10401 Thunderbird Boulevard
Sun City, Arizona 85372
Telephone (602) 977-7211



October 26, 1987

Henry Krakauer, M.D.
Area 2D2
Meadows East Building
6325 Security Boulevard
Baltimore, Maryland 21207

Dear Dr. Krakauer:

DATA VERIFICATION

The Walter O. Boswell Memorial Hospital (#030061) has performed verification procedures on the HCFA mortality data. The hospital believes the mortality data presented concerning its 6,953 Medicare admissions during 1986 essentially is correct except for two cases which do not appear in the hospital's records.

INTERPRETIVE REMARKS

As the data indicate, Boswell's actual mortality rate for Medicare deaths from all causes is 12 percent, which is well within the predicted range. Of the 16 specific diagnostic categories, only two deviate from the predicted ranges. One of these (sepsis) falls below the expected range. The other diagnostic category (severe acute heart disease) exceeds the predicted mortality range by one percentage point. This exception has received more intense data analysis, and the significant results follow.

Four documented characteristics of this group of admissions serve to describe the exceptional severity of this group's condition. The first descriptive statistic is that 118 or 90% of the 131 patients were admitted through the Emergency Department, indicating that this subset was in distress before admission.

The second characteristic of interest is that 47 or 36% of the patients in this category went into cardiac arrest at, or shortly after, admission. Once again, this is an indication that the patients were in acute distress when they arrived at the hospital.

Sixty-nine or 53% of the patients remained in the hospital with orders to forgo the use of heroic measures to prolong life. The hospital respected their rights in this regard. This factor in and of itself, might significantly influence the predicted range.

Finally, 38 or 29% had previously been patients at Boswell during the year. This indicates that at least one other time these patients had improved to the point of being discharged.

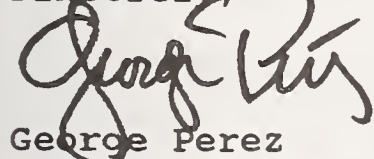
In summary, Boswell's overall mortality rate is well within the statistically predicted range, with only one diagnostic category slightly exceeding the predicted level. More than adequate documentation of factors unincorporated into the statistical model has been found to explain the variance of the actual mortality rate as reported.

GENERAL COMMENTS

While the current HCFA mortality data are helpful to hospitals and consumers as a way to identify areas for further evaluation, they should not be used as an absolute measure of quality. The time period being studied still is too short to show consistent trends. The lack of an acceptable method for measuring severity of illness and other co-morbidities also hampers this effort. The still-unknown reliability of the model that HCFA used to construct these data is of major concern. Finally, until the HCFA model is validated, quality judgements can be made only on the basis of a case-by-case review of each patient's medical record.

The Walter O. Boswell Memorial Hospital has an active, ongoing quality assurance program which involves both medical staff and hospital staff. Concerted effort is made through the quality assurance and peer review programs to prevent problems from arising. The quality assurance program is designed to identify potential problems in patient care; to study them in a multidisciplinary forum; and to implement remedies as appropriate. Physician peer reviews study individual cases which that do not meet specific criteria. For instance, all of the cases which were listed under the severe acute heart disease category had been reviewed through the hospital's quality assurance program as a matter of routine review. The HCFA data simply triggered a second review. Boswell will continue to actively pursue excellence in patient care.

Sincerely,



George Perez
Executive Vice President

GP:CS:rc

cc: W. A. Turner
Haakon Bang, Ph.D.
John J. Brennan, M.D.
John Rivers
Arizona Hospital Association

YAVAPAI REGIONAL MEDICAL CENTER
PRESCOTT, ARIZONA
MEDICARE PROVIDER NUMBER 030012

Response to HCFA Mortality Data:

A. Data Verification

The data used by HCFA indicate that for 1986 a total of 168 Medicare patients admitted to Yavapai Regional Medical Center died within 30 days of admission. Of these, 131 died while still a patient of the Medical Center, while 37 died after discharge. Our records indicate that 2,315 Medicare admissions occurred in 1986. This number differs from HCFA's data of 1,530 cases because of multiple admissions of individual patients to our hospital and other hospitals.

B. Interpretive Remarks

As a part of the ongoing, systematic quality review process at Yavapai Regional Medical Center, we carefully analyzed the HCFA mortality data for our institution. The highest actual mortality rate is in the diagnostic category of severe acute heart disease which is considered a high risk disease category. That actual rate is 49%, but it still falls within the range of predicted mortality rate for that disease (27% to 52%). An intensive analysis of the medical records was completed and the following information was learned about severe acute heart disease:

- These deaths occurred in patients with many complicating health conditions such as diabetes, chronic lung disease, and hypertension. These additional health factors enhanced the possibility of death.
- More than 80 percent of these patients were over 70 years of age. The age of the patient was a factor in the actual mortality rate.
- These patients had very severe and acute heart problems such as a massive heart attack. They were admitted in serious condition.
- Over half of all the patients in this category were so ill that death occurred within the first 24 hours of admission despite very intensive treatment.

There are a few environmental factors which should also be considered in explaining the mortality rate for severe acute heart disease:

- Nearly 60% of Yavapai Regional Medical Center's patient days are accounted for by the Medicare-eligible population (age 65 or over).
- Heart disease is defined as one of the three main diseases causing a high incidence of death in the American population.
- Despite excellent pre-hospital care staff operating a well-coordinated emergency medical system in West Yavapai County, the fact is that Yavapai Regional Medical Center serves a large geographic region of west Yavapai County and is the sole provider for many miles in any direction. Because of distance considerations, ambulance rides are extended for many miles.

C. General Comments

While the 1986 HCFA mortality data are helpful to hospitals and consumers as a way to identify areas for further evaluation, they should not be used as an absolute measure of quality. The time period being studied is still too short to show any kind of consistent trend. Likewise, the lack of an acceptable method for measuring severity of illness and other comorbidities also hampers this effort. Finally, the still unknown reliability of the model that HCFA used to construct these data is in need of further testing and refinement. As a result of these factors, quality judgments can be made only on the basis of a case-by-case review of each patient's medical record.

The individual medical record review process forms the basis for the ongoing, systematic quality review function at Yavapai Regional Medical Center. Using clinical standards developed for the various medical specialty areas, medical records are reviewed for appropriateness and effectiveness of patient care by medical staff members. Problem areas are identified and action plans are developed and implemented to resolve the issues. These action plans are documented and evaluated to ensure impact. They provide the foundation to verify to the Joint Commission on Accreditation of Healthcare Organizations that Yavapai Regional Medical Center is systematically identifying opportunities to enhance quality care and is acting to address those opportunities.

Arkansas

Medicare Hospital Mortality Information

HOSPITALS		High Risk Diagnostic Categories																							
		Overall			Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
Name/Location	Comment/Reference																								
ARKANSAS METHDDIST HOSPITA PARAGOULD AR 72450	AR-9 *	1505	13	9-16	81	37	15-36	43	44	18-45	31	16	6-35	82	33	15-34	52	42	26-53	28	11	7-39	164	15	13-28
ASHLEY MEMORIAL HOSPITAL CROSSETT AR 71635	AR-10 *	422	18	9-18	15	47	11-55	18	50	13-53	10	0	5-55	23	39	15-52	21	67	18-58	10	40	5-56	64	19	11-31
BAPTIST MEDICAL CENTER LITTLE ROCK AR 72201	AR-11	5594	8	7-13	397	24	22-36	121	22	20-38	82	5	8-27	168	16	17-31	113	38	28-48	76	22	9-31	259	14	13-25
BAPTIST MEMORIAL HOSP EAST HARDY AR 72542	AR-12	251	20	10-21	10	60	20-75	5	40	7-76	6	17	2-63	41	44	13-39	10	50	14-69	13	31	5-50	33	27	8-35
BAPTIST MEMORIAL HOSPITAL FORREST CITY AR 72335	AR-13	619	17	9-17	30	40	12-45	32	47	15-46	22	23	5-39	31	23	10-40	32	47	24-58	15	33	6-48	75	25	10-30
BATES MEM HOSP BENTONVILLE AR 72712	AR-14 *	528	14	8-16	40	18	8-35	16	38	9-50	12	8	3-47	19	21	8-44	31	58	23-57	10	10	3-53	55	22	12-34
BAXTER COUNTY REGIONAL HDS MOUNTAIN HOME AR 72653	AR-15 *	1630	12	8-15	144	19	14-32	42	33	14-41	39	21	6-32	88	26	16-35	69	49	25-49	29	14	7-38	117	16	12-28
BOONEVILLE CITY HOSP BOONEVILLE AR 72927	AR-16 *	337	15	11-21	12	67	17-68	10	60	11-65	6	17	2-64	21	24	9-44	22	45	21-61	9	11	2-53	75	13	12-32
BRADLEY CO MEM HDSP WARREN AR 71671	AR-17 *	638	15	9-17	15	80	19-66	21	48	13-50	13	15	3-45	30	23	11-41	33	42	26-59	10	30	5-55	53	21	11-34
BUFFALO ISLAND COMMUNITY H MANILA AR 72442	AR-18 *	84	23	7-23	2	100	6-94	1	100	0-97				9	56	5-58	3	0	4-85	1	0	0-100	21	24	7-41
BULL SHDALS COMM HOSP CLI BULL SHOALS AR 72619	AR-19	378	14	9-18	14	50	9-54	12	25	9-57	8	25	5-60	33	27	11-40	25	40	22-59	3	33	2-82	52	17	11-34
CARRDL GENERAL HOSPITAL BERRYVILLE AR 72616	AR-20 *	414	19	11-21	18	22	9-48	16	50	15-59	15	20	9-53	18	22	8-46	15	27	21-68	21	10	10-48	67	33	16-38
CENTRAL ARKANSAS GENERAL H SEARCY AR 72143	AR-21	1368	12	8-15	89	18	14-35	56	34	19-44	32	16	6-34	53	30	13-36	43	60	29-59	22	5	4-38	163	13	12-26
CENTRAL OZARKS MEDICAL CEN YELLVILLE AR 72687	AR-22 *	136	12	6-18	3	100	2-81	6	50	7-72	2	0	0-92	8	25	5-60	6	33	9-74	7	14	2-61	8	25	3-57
CHICOT MEM HOSP LAKE VILLAGE AR 71653	AR-23	549	14	10-18	27	33	19-55	21	33	13-50	12	17	5-51	41	20	13-39	22	36	22-62	22	23	7-42	33	24	12-42
CLEBURNE CO HOSP HEBER SPRINGS AR 72543	AR-24 *	379	18	9-18	22	59	13-50	21	48	16-54	12	33	5-51	16	25	6-45	15	47	17-64	11	9	4-53	54	24	12-36
COMMUNITY HOSPITAL OF DEQU DE QUEEN AR 71832	AR-25 *	569	17	10-18	19	58	15-56	38	39	17-46	9	22	8-63	32	28	14-44	21	48	21-61	21	43	11-49	73	25	13-34
CONWAY CO HOSP MORRILTON AR 72110	AR-26	626	12	10-18	20	40	17-58	29	41	15-48	10	20	5-56	37	14	11-39	14	29	14-61	19	0	4-40	85	21	15-35
CONWAY REGIONAL HOSP INC CONWAY AR 72032	AR-27	883	16	10-17	28	43	12-45	41	34	17-46	26	19	6-37	58	22	14-37	35	43	22-54	29	41	12-46	102	23	13-30
CORNING COMMUNITY HDSP CORNING AR 72422	AR-28 *	181	18	7-18	3	67	5-86	3	67	4-84	3	0	0-82	10	20	5-55	7	57	11-73	9	33	4-56	27	26	8-39
CRAWFORD CO MEMORIAL HOSPI VAN BUREN AR 72956	AR-29 *	592	11	8-16	31	16	11-42	27	33	16-50	13	15	3-45	30	10	10-40	34	50	24-57	15	13	4-44	50	16	10-33
CRITTENOE MEMORIAL HOSP WEST MEMPHIS AR 72301	AR-30 *	1255	13	9-16	93	16	14-35	64	36	17-39	34	15	8-36	63	17	12-33	31	32	23-57	40	25	8-36	88	32	13-32
CROSS CO HDSP WYNNE AR 72396	AR-31 *	424	16	9-17	19	68	15-57	20	45	13-51	11	27	5-53	23	30	9-43	11	36	14-66	9	33	6-60	63	22	11-32
DALLAS COUNTY HOSPITAL FORDYCE AR 71742	AR-32 *	298	14	9-19	10	60	9-62	9	33	8-63	4	25	1-74	22	18	9-44	14	50	24-73	14	7	4-47	42	19	9-34
DARDANELLE HOSPITAL DARDANELLE AR 72834	AR-33 *	272	12	8-18	11	36	18-71	16	13	12-54	10	10	3-52	19	42	10-49	14	50	16-63	1	D	0-98	28	18	7-37
DELTA MEDICAL CTR BRINKLEY AR 72021	AR-34 *	158	13	9-22	4	0	6-80	7	14	6-65	9	33	3-54	12	17	8-55	9	56	17-75	6	0	2-64	19	26	6-43

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

AR-2

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Dphthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
ARKANSAS METHODIST HOSPITA PARAGOULD AR 72450	16	31	12-59	26	42	21-60	25	4	3-30	4	0	0-100	195	5	2-9	111	7	2-13	8	0	0-98	136	4	2-10	66	2	0-11
ASHLEY MEMORIAL HOSPITAL CROSSETT AR 71635	4	0	1-76	4	25	5-79	4	25	0-80	.	.	.	32	9	2-23	17	6	1-34	3	0	0-100	36	3	1-20	29	0	0-34
BAPTIST MEDICAL CENTER LITTLE ROCK AR 72201	41	27	11-45	17	35	17-62	123	6	3-14	81	0	0-14	511	2	3-8	195	4	2-11	35	0	0-87	1034	3	3-7	437	1	0-4
BAPTIST MEMORIAL HOSP EAST HAROY AR 72542	4	50	9-85	3	0	5-86	.	.	.	.	.	.	21	0	0-30	6	0	0-79	.	.	.	17	0	0-33	9	0	0-83
BAPTIST MEMORIAL HOSPITAL FORREST CITY AR 72335	8	25	2-60	7	43	8-70	15	7	4-42	3	0	0-100	76	11	1-12	43	12	1-19	4	0	0-100	52	2	1-14	19	0	0-68
BATES MEM HOSP BENTONVILLE AR 72712	5	60	5-74	2	0	2-90	25	16	2-29	.	.	.	71	4	1-13	48	2	0-17	7	0	0-100	59	5	1-14	26	0	0-34
BAXTER COUNTY REGIONAL HDS MDUNTAIN HDME AR 72653	15	27	8-55	5	100	10-81	52	12	3-20	10	0	0-99	224	3	2-8	138	4	1-11	20	0	0-93	94	4	2-11	106	0	0-8
BOONEVILLE CITY HOSP BOONEVILLE AR 72927	6	33	6-72	6	0	10-76	1	0	0-99	.	.	.	38	3	1-19	1	0	0-99	4	0	0-100	31	0	1-20	9	0	0-79
BRAOLEY CO MEM HDSP WARREN AR 71671	15	60	11-60	4	50	4-78	19	16	3-35	.	.	.	70	3	2-14	24	4	2-29	4	0	0-100	56	4	1-14	37	3	0-20
BUFFALO ISLAND COMMUNITY H MANILA AR 72442	3	33	3-84	.	.	.	.	.	.	.	.	.	3	0	0-97	3	0	0-99	.	.	.	12	0	0-50	1	0	0-100
BULL SHDALS COMM HOSP CLI BULL SHDALS AR 72619	4	25	8-84	1	0	0-97	1	0	0-99	.	.	.	38	0	1-20	6	0	2-62	.	.	.	56	5	1-14	11	0	0-84
CARROLL GENERAL HDSPITAL BERRYVILLE AR 72616	8	75	10-71	7	71	12-75	.	.	.	.	.	.	52	4	1-15	36	6	1-21	2	0	0-100	38	8	1-19	3	0	0-99
CENTRAL ARKANSAS GENERAL H SEARCY AR 72143	15	60	15-64	8	38	14-74	35	9	2-23	4	0	0-100	147	7	2-10	60	2	1-16	14	0	0-99	130	2	2-11	92	3	0-8
CENTRAL DZARKS MEDICAL CEN YELVILLE AR 72687	1	0	0-97	.	.	.	.	.	.	.	.	.	8	0	1-53	.	.	.	.	.	.	12	8	0-43	4	0	0-100
CHICOT MEM HDSP LAKE VILLAGE AR 71653	8	25	5-64	17	35	14-58	.	.	.	1	0	0-100	66	5	1-13	15	20	1-36	4	0	0-100	57	4	1-14	18	0	0-48
CLEBURNE CO HOSP HEBER SPRINGS AR 72543	11	27	4-55	1	100	1-97	8	13	0-54	.	.	.	41	2	1-17	11	18	0-53	7	0	0-99	50	4	1-15	5	0	0-97
COMMUNITY HDSPITAL DF OEQU DE QUEEN AR 71832	8	25	6-66	1	0	1-97	10	20	0-48	.	.	.	78	1	2-13	7	14	0-59	3	0	0-100	71	6	2-13	21	0	0-35
CONWAY CO HOSP MDRRILTON AR 72110	20	20	8-50	6	33	9-76	7	0	3-60	.	.	.	56	7	2-17	49	6	2-19	4	0	0-100	43	0	1-17	31	0	0-21
CONWAY REGIONAL HDSP INC CONWAY AR 72032	16	25	10-56	12	42	13-64	29	3	2-25	14	0	0-99	87	1	2-12	23	13	1-28	2	0	0-100	93	8	2-11	26	0	0-25
CORNING COMMUNITY HDSP CORNING AR 72422	1	100	1-98	2	50	2-90	1	100	0-97	.	.	.	26	0	0-24	11	0	0-45	1	0	0-100	20	5	0-29	3	0	0-90
CRAWFORD CO MEMORIAL HDSP VAN BUREN AR 72956	7	57	11-75	8	25	9-67	19	16	2-33	2	0	0-100	62	2	1-14	38	5	1-20	2	0	0-100	41	0	1-17	42	0	0-21
CRITTENDEN MEMORIAL HDSP WEST MEMPHIS AR 72301	18	11	8-51	14	36	13-61	32	9	3-26	5	0	0-100	128	4	2-11	92	12	3-15	15	7	0-95	94	7	2-12	52	2	0-15
CROSS CO HOSP WYNNE AR 72396	8	38	7-66	4	0	4-79	.	.	.	.	.	.	55	5	1-15	15	7	1-36	1	0	0-100	54	0	1-15	9	0	0-97
DALLAS COUNTY HDSPITAL FOROYCE AR 71742	4	50	4-79	4	75	8-83	1	0	0-100	.	.	.	29	3	1-22	6	0	0-63	1	0	0-100	27	0	1-23	10	0	0-75
DAROANELLE HDSPITAL DARDANELLE AR 72834	3	0	0-92	.	.	.	.	.	.	.	.	.	39	0	1-19	11	0	0-57	3	0	0-100	17	0	1-32	11	0	0-70
DELTA MEDICAL CTR BRINKLEY AR 72021	5	0	5-75	1	0	1-97	1	0	0-98	.	.	.	20	5	1-29	1	0	0-100	.	.	.	21	0	1-27	2	0	0-100

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

				High Risk Diagnostic Categories																					
		Overall			Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
HOSPITALS		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
Name/Location	Comment/Reference																								
DELTA MEMORIAL HOSPITAL AS OUMAS AR 71639	AR-35	321	17	9-19	10	70	18-74	13	31	9-54	7	57	3-60	18	28	7-45	11	64	19-72	18	33	7-46	32	38	13-43
DERMOTT-CHICOT MEM HOSP DERMOTT AR 71638	AR-36 *	159	7	7-19	4	75	11-87	9	0	10-65	1	0	0-99	7	0	4-61	6	33	9-74	7	0	2-60	18	6	6-43
DEWITT CITY HOSP OE WITT AR 72042	AR-37 *	223	17	10-21	6	83	9-75	21	48	15-53	7	29	7-67	15	20	8-50	5	40	8-78	5	0	3-70	29	21	11-42
DOCTORS HOSP LITTLE ROCK AR 72205	AR-38 *	1343	9	7-14	98	19	15-35	32	19	15-46	36	11	6-32	39	18	10-36	32	38	22-55	17	29	9-51	53	21	11-33
OREW MEMORIAL HOSPITAL MONTICELLO AR 71655	AR-39 *	304	15	9-18	6	100	8-73	13	46	11-58	10	20	7-59	14	43	9-52	14	50	16-64	15	20	8-51	32	13	10-39
ENGLANO HOSPITAL ENGLAND AR 72046	AR-40 *	30	23	4-29	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	12	33	5-50	
EUREKA SPRINGS HOSPITAL EUREKA SPRINGS AR 72632	AR-41 *	151	16	10-22	6	33	6-70	8	25	6-63	10	30	3-51	8	25	6-62	8	25	22-82	5	20	1-68	19	16	8-46
FAYETTEVILLE CITY HOSP FAYETTEVILLE AR 72701	AR-42 *	335	15	9-19	14	29	9-54	9	22	8-62	3	33	1-82	12	33	8-55	15	20	18-65	17	24	4-42	59	10	12-34
FULTON COUNTY HOSPITAL SALEM AR 72576	AR-43 *	524	14	8-17	8	50	10-68	14	29	13-59	12	25	6-52	28	39	10-41	23	52	18-57	9	33	11-67	81	17	11-29
GRAVETTE MEDICAL CENTER HO GRAVETTE AR 72736	AR-44	420	13	10-18	17	35	7-46	20	20	12-50	10	10	1-49	30	17	11-41	32	44	23-56	15	13	5-46	63	5	8-28
GURDON MUNICIPAL HOSPITAL GURDON AR 71743	AR-45 *	37	16	6-30	.	.	.	3	100	3-83	3	33	2-82	2	0	1-89	.	.	.	1	0	0-98	9	22	6-59
HARRIS HOSP CLINIC INC NEWPORT AR 72112	AR-46	541	10	7-15	18	50	15-58	11	27	12-63	10	10	2-50	27	19	11-44	9	67	13-69	12	25	7-54	64	17	10-31
HELENA HOSP HELENA AR 72342	AR-47 *	942	16	9-16	46	46	14-42	42	40	19-48	17	18	5-43	62	37	15-37	22	45	19-58	53	23	9-33	72	14	9-28
HOT SPRING CO MEMORIAL HOS MALVERN AR 72104	AR-48 *	716	17	9-17	30	40	13-46	30	37	17-50	15	20	4-44	29	21	10-41	33	67	24-57	27	22	6-38	76	22	12-32
HOWARD MEMORAL HOSPITAL NASHVILLE AR 71852	AR-49 *	434	15	11-20	21	43	11-50	16	31	10-52	11	27	1-46	36	17	11-39	14	36	18-66	12	42	6-53	63	19	13-35
HUNTSVILLE MEMORIAL HOSPIT HUNTSVILLE AR 72740	AR-50	279	15	9-19	14	57	11-56	12	42	8-55	11	27	5-52	16	31	8-48	8	50	14-74	10	10	3-52	45	16	13-39
JEFFERSON REGIONAL MEO CEN PINE BLUFF AR 71603	AR-51 *	3357	11	9-15	302	20	19-34	130	27	20-37	77	10	9-29	171	19	18-32	120	41	30-49	85	22	11-32	191	16	14-28
JOHNSON CO REGIONAL HOSP CLARKSVILLE AR 72830	AR-52 *	609	12	9-17	38	37	20-51	24	25	13-48	12	17	3-48	25	28	10-43	26	54	25-62	8	13	4-59	64	19	11-32
LAFAYETTE CO MEMORIAL HOSP LEWISVILLE AR 71845	AR-53 *	229	16	10-21	7	57	7-68	16	38	13-57	4	0	4-78	11	27	12-63	8	75	18-78	9	11	6-60	30	20	8-37
LAWRENCE MEMORIAL HOSP WALNUT RIDGE AR 72476	AR-54	435	20	12-21	19	68	15-57	19	42	13-52	10	20	3-52	38	21	13-40	30	37	24-59	8	13	3-57	64	27	15-37
LEE MEMORIAL HOSP MARIANNA AR 72360	AR-55 *	119	21	8-21	1	100	0-97	5	60	4-72	.	.	.	15	20	9-51	2	50	5-93	3	33	0-83	38	18	7-33
LEE MEMORIAL HOSPITAL MARIANNA AR 72360	AR-56 *	10	20	3-50	.	.	.	.	.	.	.	.	.	1	0	1-97	.	.	.	1	0	0-98	3	33	1-81
LITTLE RIVER MEMORIAL HOSP ASHDOWN AR 71822	AR-57 *	241	15	10-21	6	50	5-69	12	50	12-61	7	14	3-61	20	35	11-49	10	50	18-73	6	0	4-68	26	15	10-42
MAGNOLIA HOSP MAGNOLIA AR 71753	AR-58 *	605	16	11-19	24	42	18-57	35	37	16-47	12	8	3-47	37	24	13-40	36	42	24-56	29	14	8-40	77	19	11-31
MCGEHEE-OESHA CO HOSP MCGEHEE AR 71654	AR-59	223	14	9-20	6	83	15-82	12	42	8-55	6	33	2-63	16	13	8-48	15	60	18-64	13	8	3-46	23	17	9-43
MEDICAL CENTER OF CALICO R CALICO ROCK AR 72519	AR-60	240	17	10-21	15	40	12-57	6	17	5-68	7	14	2-60	8	25	5-59	20	50	20-61	5	0	2-70	40	25	12-39

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

AR-4

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
DELTA MEMORIAL HOSPITAL AS OUMAS AR 71639	8	13	7-66	1	0	1-97	3	0	0-86	.	.	.	39	3	1-18	13	8	2-41	1	0	0-100	18	0	0-32	14	0	0-57
OERMOTT-CHICOT MEM HOSP OERMOTT AR 71638	2	0	3-92	.	.	.	.	.	.	.	.	.	14	0	0-38	2	50	0-97	.	.	.	13	0	0-41	6	0	0-94
DEWITT CITY HOSP OE WITT AR 72042	4	0	2-77	2	100	2-91	1	0	0-100	.	.	.	22	5	0-27	6	17	0-65	.	.	.	14	0	0-37	12	0	0-64
DOCTORS HOSP LITTLE ROCK AR 72205	15	33	11-59	15	53	19-67	30	13	4-30	57	0	0-32	179	6	2-9	80	3	1-13	36	0	0-48	122	1	2-10	93	0	0-8
OREW MEMORIAL HOSPITAL MONTICELLO AR 71655	5	0	1-71	5	20	8-77	2	0	0-98	.	.	.	32	3	1-21	8	25	0-54	6	0	0-86	34	9	1-20	10	0	0-70
ENGLANO HOSPITAL ENGLANO AR 72046	2	50	1-90	.	.	.	.	.	.	.	.	.	2	0	0-99	1	0	0-99	.	.	.	2	50	0-95	1	0	0-100
EUREKA SPRINGS HOSPITAL EUREKA SPRINGS AR 72632	1	0	0-99	5	40	10-80	.	.	.	.	.	.	17	6	0-33	3	0	0-92	.	.	.	19	5	0-30	5	20	0-73
FAYETTEVILLE CITY HOSP FAYETTEVILLE AR 72701	5	20	4-73	5	20	7-77	3	0	1-81	.	.	.	28	14	1-23	15	33	0-38	.	.	.	33	0	1-20	11	18	0-78
FULTON COUNTY HOSPITAL SALEM AR 72576	5	40	1-71	2	50	6-94	5	0	1-67	.	.	.	61	0	1-14	14	14	1-38	2	0	0-100	51	8	2-17	18	0	0-37
GRAVETTE MEDICAL CENTER HO GRAVETTE AR 72736	10	20	6-60	3	67	7-89	1	0	0-99	1	0	0-100	44	7	1-18	11	27	1-44	4	0	0-100	52	4	1-15	8	0	0-54
GURDON MUNICIPAL HOSPITAL GURDON AR 71743	.	.	.	.	.	.	.	.	.	.	.	.	3	0	0-95	2	0	0-90	.	.	.	3	0	0-95	2	0	0-100
HARRIS HOSP CLINIC INC NEWPORT AR 72112	2	50	2-91	2	0	0-90	8	0	1-53	.	.	.	73	4	2-13	20	5	1-30	7	0	0-100	61	3	1-14	36	0	0-18
HELENA HOSP HELENA AR 72342	21	43	15-58	11	73	18-72	8	13	1-53	6	0	0-100	75	1	1-12	69	3	1-15	9	11	0-77	79	10	2-12	32	3	0-25
HOT SPRING CO MEMORIAL HOS MALVERN AR 72104	17	41	8-53	4	75	3-77	.	.	.	.	.	.	47	2	1-16	47	13	2-20	2	0	0-100	76	7	2-13	33	3	0-21
HOWARD MEMORIAL HOSPITAL NASHVILLE AR 71852	7	29	9-72	15	40	17-64	2	0	0-94	.	.	.	51	2	1-16	5	0	1-68	.	.	.	33	3	1-21	7	0	0-86
HUNTSVILLE MEMORIAL HOSPIT HUNTSVILLE AR 72740	6	17	5-70	.	.	.	1	0	0-100	.	.	.	34	0	1-19	20	0	0-33	.	.	.	20	10	1-29	3	0	0-100
JEFFERSON REGIONAL MED CEN PINE BLUFF AR 71603	38	26	12-47	20	50	18-60	99	6	4-16	6	17	0-100	417	6	3-9	246	3	2-11	27	0	0-68	209	5	2-9	177	1	0-5
JOHNSON CO REGIONAL HOSP CLARKSVILLE AR 72830	3	100	12-93	5	0	7-77	19	21	2-33	4	0	0-100	78	1	2-13	24	4	1-28	9	0	0-100	60	2	1-14	22	0	0-32
LAFAYETTE CO MEMORIAL HOSP LEWISVILLE AR 71845	2	100	3-91	3	33	7-88	.	.	.	.	.	.	28	0	1-22	2	50	0-98	.	.	.	12	17	1-41	9	0	0-90
LAWRENCE MEMORIAL HOSP WALNUT RIDGE AR 72476	7	57	11-75	1	100	1-97	1	100	0-97	.	.	.	38	5	1-19	25	24	2-28	1	0	0-100	38	0	1-19	7	14	0-71
LEE MEMORIAL HOSP MARIANNA AR 72360	4	50	1-76	1	0	1-97	.	.	.	.	.	.	10	10	0-55	11	0	0-54	.	.	.	4	25	0-94	.	.	.
LEE MEMORIAL HOSPITAL MARIANNA AR 72360	.	.	.	.	.	.	.	.	.	.	.	.	1	100	0-100	.	.	.	.	.	.	.	.	.	.	.	.
LITTLE RIVER MEMORIAL HOSP ASHDOWN AR 71822	4	25	2-77	8	38	17-78	.	.	.	.	.	.	15	7	0-36	5	40	1-67	1	0	0-100	29	3	1-23	18	0	0-41
MAGNOLIA HOSP MAGNOLIA AR 71753	19	37	12-56	6	33	14-81	5	20	1-68	1	0	0-100	70	3	1-13	15	27	2-38	.	.	.	57	2	1-14	23	0	0-38
MCGEEHEE-DESHA CO HOSP MCGEEHEE AR 71654	3	0	1-82	.	.	.	1	0	0-99	1	0	0-100	20	0	1-29	6	17	2-63	.	.	.	20	0	1-29	10	0	0-83
MEDICAL CENTER OF CALICO R CALICO ROCK AR 72519	5	60	4-74	2	50	2-90	1	0	0-99	.	.	.	26	4	1-24	8	0	0-83	3	0	0-100	28	14	1-22	9	0	0-87

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

		High Risk Diagnostic Categories																							
		Overall			Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
HOSPITALS		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
Name/Location	Comment/Reference																								
MEDICAL PARK HOSPITAL HOPE AR 71801	AR-61	441	14	8-17	12	50	11-61	21	24	13-50	15	27	7-48	26	38	8-40	15	60	19-66	13	15	4-48	56	18	11-34
MEMORIAL HOSP LITTLE ROCK AR 72114	AR-62	1859	12	8-14	121	26	18-37	66	29	17-39	27	7	5-36	84	20	14-32	66	36	27-51	66	24	10-33	122	18	10-26
MERCY HOSPITAL OF SCOTT CO WALDRON AR 72958	AR-63	211	16	10-21	6	67	8-74	8	38	10-68	7	14	2-59	16	38	10-51	13	31	16-65	12	17	5-52	28	18	6-36
METHODIST HOSP OF JONESBOR JONESBORO AR 72401	AR-64	1148	11	7-14	59	27	11-35	28	32	10-42	18	22	5-42	58	28	14-36	42	48	27-57	22	14	6-42	95	20	9-26
MISSISSIPPI COUNTY HOSP BL BLYTHEVILLE AR 72315	AR-65	946	15	9-16	46	35	15-42	36	31	15-45	28	14	4-33	62	35	12-33	35	34	24-57	28	18	6-38	109	20	15-32
MISSISSIPPI COUNTY HOSPITA OSCEOLA AR 72370	AR-66	413	14	8-17	10	50	12-67	23	30	11-47	11	18	4-51	31	16	10-39	16	31	19-65	22	32	5-40	41	17	8-33
NATIONAL PARK MEDICAL CENT HOT SPRINGS AR 71901	AR-67 *	1232	9	7-13	68	16	13-36	38	24	16-44	21	5	7-42	43	28	13-38	25	44	23-60	27	33	8-40	78	12	10-29
NEWPORT HOSP CLINIC INC NEWPORT AR 72112	AR-68 *	618	8	7-15	12	25	8-55	8	38	8-65	15	7	4-44	27	22	9-41	7	57	11-73	19	5	7-46	73	18	12-32
NORTH ARKANSAS MEDICAL CEN HARRISON AR 72601	AR-69 *	1494	10	9-16	116	21	15-34	57	19	17-41	31	13	7-36	54	13	12-35	58	38	27-52	34	9	7-37	172	23	15-29
NORTH LOGAN MEMORIAL HOSP PARIS AR 72855	AR-70	180	16	9-21	17	41	17-61	5	20	4-71	6	33	3-66	15	20	6-46	9	33	16-73	2	0	0-89	14	43	7-50
OUACHITA CO HOSP CAMOEN AR 71701	AR-71 *	1062	13	8-15	34	44	12-43	34	35	16-46	17	12	4-42	70	29	13-33	32	41	23-57	55	27	8-33	134	14	12-27
PIGGOTT COMMUNITY HOSP PIGGOTT AR 72454	AR-72	350	17	9-18	9	78	13-70	8	38	9-66	5	0	1-68	20	20	10-47	23	39	22-61	7	0	1-59	32	28	7-35
PIKE CO MEMORIAL HOSP MURFREESBORO AR 71958	AR-73 *	161	11	8-19	7	57	7-68	1	100	0-97	3	0	1-81	9	22	7-61	9	22	13-70	9	44	5-58	19	5	5-40
RANDOLPH COUNTY MEDICAL CE POCAHONTAS AR 72455	AR-74	395	16	9-17	19	42	15-56	7	43	7-68	10	30	5-54	18	33	11-51	9	44	12-68	16	50	7-49	53	26	11-34
REBSAMEN MEM HOSP JACKSONVILLE AR 72076	AR-75 *	721	16	9-16	30	40	14-47	40	38	14-41	18	28	6-44	37	27	11-38	25	48	22-59	26	12	5-37	82	26	12-31
RIVERVIEW MEDICAL CENTER LITTLE ROCK AR 72201	AR-76 *	242	7	7-18	21	19	9-47	7	43	6-65	5	40	4-71	14	7	7-50	9	22	16-73	3	33	3-83	11	9	6-54
SALINE MEM HOSP BENTON AR 72015	AR-77	942	13	7-15	17	6	5-44	38	26	14-42	15	33	4-43	44	32	13-38	31	35	23-57	24	17	8-42	98	28	12-29
SILOAM SPRINGS MEMORIAL HO SILOAM SPRINGS AR 72761	AR-78	491	14	9-18	30	20	8-39	16	44	13-56	12	17	4-50	27	15	10-41	25	40	21-58	9	0	2-53	75	27	13-34
SOUTHWEST MEDICAL CENTER PRESCOTT AR 71857	AR-79 *	273	16	9-19	13	62	14-63	8	25	9-67	6	17	2-64	6	0	5-68	14	43	16-64	10	20	5-55	53	21	11-34
SPARKS REGIONAL MEDICAL CE FORT SMITH AR 72901	AR-80	4050	10	9-15	297	18	18-33	115	25	21-39	76	16	10-31	248	20	18-30	145	33	28-46	55	20	13-38	253	22	15-28
SPRINGDALE MEM HOSP SPRINGDALE AR 72764	AR-81	1543	12	8-15	71	24	14-37	51	22	18-43	34	15	9-38	68	34	14-34	77	47	26-49	28	18	7-39	127	25	13-30
ST BERNARD'S REGIONAL MEO C JONESBORO AR 72401	AR-82 *	3117	11	7-13	218	24	13-29	105	27	18-36	82	16	9-29	97	22	14-32	97	41	26-46	64	23	9-32	189	20	13-27
ST EDWARDS MERCY MEO CENTE FORT SMITH AR 72903	AR-83	3100	12	8-15	251	27	18-34	111	29	19-37	76	11	9-29	117	20	15-31	100	44	28-48	51	22	7-31	225	17	14-27
ST JOSEPH'S REGIONAL HEALTH HOT SPRINGS AR 71901	AR-84	3215	12	9-15	216	27	20-37	106	28	20-39	63	22	10-31	108	32	17-34	106	35	29-50	47	26	10-36	217	28	15-29
ST MARY ROGERS MEMORIAL HO ROGERS AR 72756	AR-85	1373	12	8-15	108	23	14-34	38	45	14-43	37	14	9-37	64	22	13-33	53	49	26-53	20	15	7-44	96	22	11-28
ST MARYS HOSPITAL INC RUSSELLVILLE AR 72801	AR-86 *	1451	11	9-15	62	23	13-37	55	27	17-41	31	26	7-36	86	26	15-33	66	38	26-50	28	7	7-39	148	21	13-28

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

AR-6

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
MEIOCAL PARK HOSPITAL HOPE AR 71801	11	0	2-53	.	.	.	1	100	0-100	.	.	.	66	5	1-14	10	0	2-48	3	0	0-100	45	2	1-16	10	0	0-78
MEMORIAL HOSP LITTLE ROCK AR 72114	11	18	5-57	10	50	8-61	70	10	3-17	12	0	0-94	234	2	2-9	93	10	2-14	40	0	0-34	118	7	2-11	134	2	0-6
MERCY HOSPITAL OF SCOTT CO WALDRON AR 72958	3	33	1-82	6	33	11-78	.	.	.	.	.	.	23	4	1-27	4	0	0-83	2	0	0-100	22	5	1-27	3	0	0-99
METHOOIST HOSP OF JONESBOR JONESBORO AR 72401	12	8	3-52	9	22	18-76	40	5	3-23	1	0	0-100	154	4	2-9	73	7	1-15	17	0	0-91	72	3	1-12	55	4	0-13
MISSISSIPPI COUNTY HOSP BL BLYTHEVILLE AR 72315	13	23	3-51	16	38	12-57	24	25	1-28	16	0	0-98	86	2	2-12	59	2	1-16	11	0	0-96	71	7	1-13	21	0	0-45
MISSISSIPPI COUNTY HOSPITA OSCEOLA AR 72370	3	0	1-82	6	50	8-74	.	.	.	1	0	0-100	40	5	1-17	6	0	0-71	.	.	.	41	7	1-17	13	0	0-74
NATIONAL PARK MEOICAL CENT HOT SPRINGS AR 71901	17	24	8-53	7	43	10-72	40	13	3-23	10	0	0-100	126	7	2-11	82	1	1-14	35	0	0-85	141	5	2-10	88	1	0-9
NEWPORT HOSP CLINIC INC NEWPORT AR 72112	6	33	7-73	3	0	4-84	9	0	1-50	1	0	0-100	64	6	1-14	22	0	2-30	5	0	0-86	64	2	2-15	30	0	0-28
NORTH ARKANSAS MEOICAL CEN HARRISON AR 72601	16	25	8-54	19	32	16-58	45	2	3-22	3	0	0-100	191	5	2-9	70	1	1-15	24	0	0-90	131	2	2-10	103	0	0-8
NORTH LOGAN MEMORIAL HOSP PARIS AR 72855	4	0	2-76	1	100	0-97	2	0	0-96	.	.	.	11	0	0-51	7	0	0-71	2	0	0-100	19	5	0-29	5	0	0-99
QUACHITA CO HOSP CAMOEN AR 71701	19	37	9-52	2	100	1-89	24	8	2-28	4	0	0-100	143	3	2-10	27	19	2-27	12	0	0-97	105	1	2-11	22	0	0-41
PIGGOTT COMMUNITY HOSP PIGGOTT AR 72454	4	100	10-87	5	80	9-79	1	0	0-100	.	.	.	37	0	1-20	11	18	3-47	1	0	0-100	34	9	1-20	17	0	0-46
PIKE CO MEMORIAL HOSP MURFREESBORO AR 71958	2	0	2-90	.	.	.	.	.	.	.	.	.	16	0	0-34	5	0	0-72	.	.	.	29	0	1-22	5	0	0-91
RANDOLPH COUNTY MEOICAL CE POCAHONTAS AR 72455	8	13	2-60	.	.	.	5	0	0-68	.	.	.	46	2	1-17	19	11	1-32	1	0	0-100	40	0	1-17	22	9	0-31
REBSAMEN MEM HOSP JACKSONVILLE AR 72076	9	11	7-63	8	50	14-75	16	19	1-35	2	0	0-100	87	5	2-12	47	11	1-19	4	0	0-100	60	3	1-13	20	0	0-38
RIVERVIEW MEOICAL CENTER LITTLE ROCK AR 72201	2	0	0-92	3	0	5-85	3	33	2-82	.	.	.	32	0	1-22	14	0	0-41	1	0	0-100	25	0	1-24	5	0	0-95
SALINE MEM HOSP BENTON AR 72015	17	12	7-52	14	36	12-59	47	13	2-20	1	0	0-100	134	4	1-10	20	5	1-30	8	0	0-100	62	3	1-13	58	2	0-13
SILAM SPRINGS MEMORIAL HO SILAM SPRINGS AR 72761	11	18	4-56	2	50	4-92	1	100	0-98	5	0	0-100	77	4	2-13	16	0	1-35	2	0	0-100	58	10	1-14	8	0	0-91
SOUTHWEST MEOICAL CENTER PRESCOTT AR 71857	.	.	.	6	50	9-74	.	.	.	.	.	.	39	5	1-19	9	33	1-50	2	0	0-100	18	0	0-31	6	0	0-99
SPARKS REGIONAL MEOICAL CE FORT SMITH AR 72901	40	13	8-42	37	38	23-56	113	6	4-17	29	0	0-42	394	4	2-8	268	3	1-10	51	0	0-46	452	5	4-9	254	1	0-5
SPRINGDALE MEM HOSP SPRINGDALE AR 72764	10	50	7-62	5	40	8-79	37	14	4-27	6	0	0-100	172	6	2-10	55	2	1-17	13	0	0-99	237	3	2-8	90	1	0-8
ST BERNAROS REGIONAL MEO C JONESBORO AR 72401	33	18	10-46	25	44	24-63	94	9	3-16	13	0	0-94	274	5	2-8	158	4	1-11	46	0	0-20	311	6	2-7	297	1	0-4
ST EDWARDS MERCY MEO CENTE FORT SMITH AR 72903	16	38	13-61	27	48	24-62	110	6	3-15	21	0	0-77	333	6	4-10	181	7	2-11	30	0	0-59	341	4	3-8	151	1	0-6
ST JOSEPHS REGIONAL HEALTH HOT SPRINGS AR 71901	18	39	5-48	40	45	24-56	95	5	4-17	30	0	0-65	356	3	3-9	189	7	2-11	27	0	0-67	413	2	3-7	156	1	0-6
ST MARY ROGERS MEMORIAL HO ROGERS AR 72756	9	44	6-62	11	55	12-65	52	8	3-20	2	0	0-100	172	6	2-9	76	3	1-14	15	0	0-100	136	2	2-10	88	2	0-9
ST MARYS HOSPITAL INC RUSSELLVILLE AR 72801	12	0	3-52	16	31	16-62	45	7	2-20	5	0	0-100	169	2	2-10	62	5	2-17	22	0	0-92	127	2	2-10	107	0	0-7

*Written Comments Not Submitted.

*Written Comments Not Submitted.

COMMENTS ON THE 1986 HCFA MORTALITY DATA
Baptist Medical System
Little Rock, Arkansas

The Baptist Medical System includes three acute care hospitals, Baptist Medical Center is a 739-bed tertiary care hospital located in Little Rock; Memorial Hospital is a 260-bed community hospital in North Little Rock; Twin Rivers Medical Center is a 57-bed community hospital in Arkadelphia.

Baptist Medical System hospitals strive to be "centers of excellence." Providing quality care to our patients is of utmost concern to the governing board, medical staffs and management. We recognize the value of mortality data in the identification of potential quality problems. Periodically (monthly, quarterly, etc.), we evaluate data for trends or potential problems. If a case is questionable, we don't hesitate to take action to correct the problem and prevent further occurrences.

Although the reported data indicates that we are within (or below) the predicted range in all categories, we strongly disagree with the implication that this data can be used as a measure of quality.

Our concerns are based on the following:

1. We cannot verify the accuracy of HCFA statistics on deaths after discharge because we do not have access to the Social Security data used.
2. We received an inadequate description of the methodology used to calculate expected mortality rates. We cannot duplicate it for our own use.
3. THE MODEL HAS NOT BEEN VALIDATED. The reliability of the mode is unknown, but appears limited.
4. The patient's severity of illness is not taken into account. A hospital's mortality rate may be significantly impacted by difference in case mix.
5. A higher than average mortality rate does not necessarily mean poorer performance. A hospital may specialize in high risk cardiac and trauma surgery, or have large number of chronic lung disease patients requiring long term ventilator use, or a hospice service.

6. Attributing a patient's death to an individual hospital based solely on the fact that the patient died within 30 days of admission does not measure the quality of care provided in that facility or by the attending physician. The statistics do not take into consideration noncoded contributing diseases or complications due to lack of space on the bill. Other factors which must be considered are:
 - A. The use of medical services early in the course of the disease causing a timely diagnosis and admission for treatment.
 - B. The appropriateness of outpatient services provided.
 - C. The availability and quality of post hospital services and treatment.
 - D. The general health status of the patient, stage of illness and psychological condition.
 - E. Social factors, such as family support and dynamics.
7. There are discrepancies between the hospital's abstracted data, the local peer review organization's data and the HCFA data provided. For example, the data by HCFA indicate that a total of 5594 Medicare patients were last admitted in 1986 to Baptist Medical Center. We have no way to readily verify the number of cases, since our data is based on all Medicare admissions during 1986, which was 9117. Of those 5594 cases, 436 deaths within 30 days of admission were reported. We were able to verify only 431 of those deaths. HCFA also reported that 63 of the deaths occurred after discharge. Our records indicate that 3 of the reported deaths after discharge actually occurred in Baptist Medical Center, decreasing the number to 60.
8. The summary of mortality data does not include critical information such as age (90% of patients may be over 80 years old).

While we recognize the need to provide the consumer with valid and useful information on the quality of hospital care, we believe that better measures are needed. We are currently working with the American Hospital Association and other organizations, including the Joint Commission on Accreditation of Hospitals, to develop methods of evaluating hospital quality nationwide that rely on measures other than mortality rates.

HOSPITAL ID NUMBERS

BAPTIST MEDICAL CENTER = 040114
MEMORIAL HOSPITAL = 040036
TWIN RIVERS MEDICAL CENTER = 040066

BAPTIST MEMORIAL HOSPITAL
EASTERN OZARKS

South Allegheny Drive
Hardy, Arkansas 72542

October 26, 1987

Health Care Financing Administration
P.O. Box 26684
Baltimore, Maryland 21207

Dear Sir:

The data used by HCFA indicates that a total of 50 Medicare patients admitted to Baptist Memorial Hospital - Eastern Ozarks died within 30 days of admission. Of these, 39 died while still a patient of the hospital, while 11 died after discharge.

Our own records indicate that 3 deaths listed were actually transfers to other acute care facilities probably due to incorrect recording of discharge disposition during a transitional period under a new medical record abstracting system. One presumed hospital death was actually a death occurring in our skilled nursing Swing Bed Unit and pertained to a transfer in from another acute care facility and should not have been included in this facility's mortality statistics.

These errors result in a decrease of 4 in the total number of deaths from 50 to 46 and a decrease of 3 deaths in the Severe Chronic Heart Disease Classification which is shown by HCFA to be outside the predicted range. An in depth review of all the cases in the category of Severe Chronic Heart Disease was done and no quality problem was identified. The data revealed that these patients were admitted critically or terminally ill and death was expected or unavoidable:

- 20% of these patients were admitted under acute circumstances and expired within 24 hours of admission.
- 27% of these patients were known to be terminal at the time of admission.
- 40% of these patients were admitted through the emergency room in severe distress.

According to Hospital Summary Reports furnished by the Arkansas Foundation For Medical Care and based upon Medicare claims received, 14% of the Medicare claims received fell into DRG 127 which is the DRG that the Severe Chronic Heart Disease Category falls within.

Sharp County, Arkansas, is predominantly rural in nature and possesses a vast amount of elderly citizens. Twenty-five percent of the county's residents are 65+ years of age and constitutes two and one-half times the State's overall average. There are several retirement communities and two nursing homes in close proximity to this facility. A majority of the roads are still unpaved and impassable during inclement weather in the winter months creating many unfavorable circumstances for our elderly population.

Baptist Memorial Hospital - Eastern Ozarks has an established Quality Assurance Plan in effect to provide patient care of high quality in keeping with available resources. The quality of care rendered to our patients is evaluated through the Hospitalwide Quality Assurance Program. The program consists of a review and analysis by staff physicians, nursing service and other professional personnel including ongoing monitoring with objective, physician developed criteria and provides for recommendations, action and follow-up assessments. The Governing Body and Administrator support the Quality Assurance activities within the hospital and assume ultimate responsibility for the Quality Assurance Program.

Mortality Review is also an aspect of Quality Assurance in our Hospitals. All deaths occurring in our hospital are reviewed by the Medical Staff. No quality problems have been identified.

Baptist Memorial Hospital - Eastern Ozarks is an acute care facility that strives to provide quality patient care in a cost efficient manner without sacrifice to the patient. While we feel that the HCFA data can be beneficial in identifying potential areas for possible further evaluation, we do not feel that such data can be used directly or indirectly as a measure of hospital performance. We are proud of our facility, our medical, nursing and ancillary staff and the care that is rendered to each of our patients is no less than that to which they are entitled.

The goal of the Board of Trustees, Administration and Medical Staff is to provide optimal quality care to all patients who seek treatment at Baptist Memorial Hospital - Eastern Ozarks.

Sincerely,



Ted Spurlock
Administrator

TS/vh

BAPTIST MEMORIAL HOSPITAL
FORREST CITY

P.O. Box 667
Forrest City, Arkansas 72335

October 26, 1987

Health Care Financing Administration
P.O. Box 26684
Baltimore, MD 21207

Dear Sir:

The following summary is in response to the mortality rate identified for Baptist Memorial Hospital - Forrest City. In the diagnostic categories identified by HCFA - our facility fell within the range of predicted mortality rate in all but one category. In the area relating to cardiovascular accidents the mortality rate fell 1% above the predicted rate. An error was found in the data provided by HCFA. This error consisted of one patient that was transferred from our facility to another acute care hospital where he expired. This case should not have been represented in our statistical rate.

In reviewing hospital admissions for 1986 and the Medicare quarterly statistics provided by the Arkansas PRO, we were able to determine that patients admitted with the primary diagnosis of cardiovascular accidents represent a large percentage of our hospital case mix. Consistently each quarter, DRG14, which relates to cardiovascular accidents, rank in the top 10 DRG's for our facility.

The information provided for this summary was obtained from the fourteen records identified by HCFA as cases who died in our facility or within 30 days of hospital admission.

The data indicated that all patients were severely ill on admission and were cared for in the appropriate clinical setting. The following are factors reflecting severity:

- 53% of the patients who expired were admitted to the Intensive Care Unit.
- 93% were admitted with multiple, severe diagnosis.
- 80% were in a comatose state on admission.
- 13% died within 24 hours of admission to the hospital.

We believe that this data reflects that the identified patients were severaly ill on admission and despite appropriate care would be considered the highest risk for mortality.

Baptist Memorial Hospital - Forrest City is a JCAH accredited facility. One of the major requirements for accreditation, which has been met by our hospital, is a Quality Assurance Plan and Program approved by the Hospital Board and Medical Staff. The Hospital Staff and physician performance is assessed for quality. This assessment is dependent upon many variables and requires a review of many quality indicators with mortality being one of these indicators.

The Medical Staff at BMH - Forrest City reviews all the deaths occurring within the hospital and has found no quality problem. In conclusion, cases outside the predicted range were expected. Again, an in depth review of the cases showed no quality problem.

The goal of the Board of Trustees, Administration and Medical Staff is to provide optimal quality care to all patients who seek treatment at Baptist Memorial Hospital - Forrest City.

Sincerely,

A handwritten signature in cursive script that reads "Tom Kennedy". The signature is written in dark ink and is positioned above the printed name and title.

Thomas F. Kennedy
Administrator

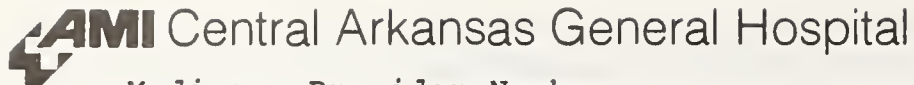
TFK/vh/399

Bull Shoals Community Hospital & Clinic, Inc.
Bull Shoals, Arkansas

Provider Number: 04-0115

The hospital's comments consisted primarily of annotations to the patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish the comments because of the numerous patient identifiers contained in the data.

David C. Laffoon
Chief Executive Officer



Medicare Provider Number
04-0014

October 21, 1987

Please include the following information for AMI Central Arkansas Hospital in the December public release of Mortality Data Statistics.

AMI Central Arkansas Hospital is a 136-bed acute care facility with a varied case mix of patients including many with major medical and surgical illnesses. Approximately 50% of admissions are Medicare patients. We are a full service hospital offering care in specialty areas of cardiology, neurology, pediatrics, oncology, dialysis, as well as general medicine and surgery.

The staff of AMI Central Arkansas Hospital conducts an intensive review of the medical record of every patient who expires here, regarding medical management and overall care. Mortality review is ongoing through the Quality Assurance Program and even further reviewed through the hospital's in-house Patient Care Accountability Program (PCAP).

The Mortality Data for AMI Central Arkansas Hospital has been carefully reviewed by hospital administration, senior management, the Director of Medical Records and Support Services, Director of Quality Assurance and Utilization Review and the Executive Medical Committee. The actual mortality rate for AMI Central Arkansas Hospital is favorable and falls within the predicted range of mortality rates for other hospitals.

We thank you for the opportunity to provide this response. We believe that consumers have a right to information on the quality of health care available to them and look forward to improved methods to evaluate hospital quality other than mortality rates.

Chief Executive Officer

October 9, 1987

Healthcare Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Sir:

I appreciate the opportunity to comment on the data being released about mortality rates at Chicot Memorial Hospital, Lake Village, Arkansas. After extensive review of the data it was noted that it appeared to be accurate.

Chicot Memorial Hospital serves a rural population with a service area including approximately 20,000 people. The area is located in the Arkansas "Delta" of the Mississippi River and is almost totally an agriculturally based economy. The average annual per capita income is \$5,970 whereas the average for Arkansas is \$8,936.¹ This statistic glaringly shows the poverty of the region. Numerous studies have directly correlated poverty and increased incidence of mortality.

The percent of population greater than 60 years old is 20.3% whereas the same statistic for Arkansas as a whole is 18.5%.² A well accepted assumption is that as age increases the percentage of deaths will increase. 3:00 P.M. TO 6:00 P.M.

The Southeastern counties of Arkansas are also designated as medically underserved areas by the U.S. Public Health Service. This less than adequate access to healthcare can also be expected to increase the incidence of mortality in the general population

The specific data suggest that overall Chicot Memorial Hospital is well within the "Range of Predicted Mortality Rates" published by HCFA. All "Diagnostic Categories" also fell within the "Predicted Mortality Rates".

1 Arkansas State and County Economic Data (Arkansas Industrial Development Commission 1985).

2 Census Of Population:1980 (U.S. Bureau of the Census, U.S. Government Printing Office 1982).

Chicot Memorial Hospital



Circumstances of deaths have not been adequately explained by the data and a more detailed reflection demonstrates some additional facts which need to be brought to light for more adequate interpretation:

- 1.) Of the 78 total deaths in 1986 at Chicot Memorial Hospital:
 - A. Fourteen (18%) occurred the same day of admission.
 - B. Thirty-three deaths (42%) occurred within 72 hours of admission.
 - C. Twenty-seven (35%) occurred within 48 hours of admission.
 - D. Twenty-one (27%) occurred within 24 hours of admission.
 - E. Average age of deaths at Chicot Memorial Hospital was 80.53 years.

The above data suggests a population which does not seek medical attention until they are in the extreme acute stage of illness.

- 2.) Eight deaths (10%) occurred following the patients' dismissal from the hospital. There was no way to confirm that these deaths were the result of the condition of the patient upon discharge or the result of unrelated circumstances.
- 3.) There were fifty-five deaths of people who were 75 years old or older. The following breakdown is by age group.

	<u>Number</u>	<u>Cumulative</u>
A. Deaths of people 90 and over =	19	19
B. Deaths of people 80 to 90 =	25	44
C. Deaths of people 75 to 80 =	11	55

Chicot Memorial Hospital serves extremes in both poverty and in age. If variables for these and other factors such as sex, race, type of employment, and access to and affordability of care were also considered and factored into the data, a significantly different picture is presented.

Chicot Memorial Hospital constantly strives to improve the quality of care rendered to its patients. Unfortunately, there is no good measure of quality at our disposal. The mortality data has significant shortcomings and should not be interpreted as an absolute measure of "quality", even though the hospital is presented positively by the data.

Sincerely,

Dan Smigelski
Dan Smigelski
Administrator

DS/lw



Conway County Hospital

Operated by the Sisters of Saint Benedict



4 HOSPITAL DRIVE, P.O. BOX 31
MORRILTON, ARKANSAS 72110
(501) 354-3512

Office of the Administrator

October 23, 1987

Medicare Provider # 04 0003

In response to your mortality data on 1986 Medicare deaths associated with our hospital, the following is provided:

The average age of all Medicare patients who died while hospitalized at Conway County Hospital or within 30 days of discharge is 79.7 years.

The average age of all male Medicare patients who died while hospitalized at Conway County Hospital or within 30 days of discharge is 79 years.

The average age of all female Medicare patients who died while hospitalized at Conway County Hospital or within 30 days of discharge is 80.3 years.

In all the above cases, the average age at death of Medicare patients hospitalized at Conway County Hospital is greater than the 1986 national average life expectancy combined (74.9 years), of males (71.3 years), and of females (78.3 years).

Such elderly patients have multiple problems of increased severity with their general well-being reflecting the complications of age well beyond the national life expectancy.



BILL LANGFORD
Executive Director

October 21, 1987

Dr. William L. Roper, Administrator
HCFA
Professional Building
6325 Security Blvd.
Baltimore, Maryland 21207

RE: HCFA Mortality Report

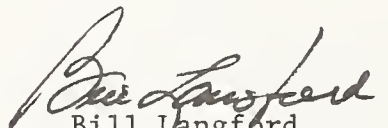
Dear Dr. Roper:

The data used by HCFA in preparing the mortality report for this hospital contained accurate information as regards deaths occurring in the hospital. One entry, however, was noted to be incorrect. [REDACTED] was listed as expiring on 2-12-86 and the patient expired 2-20-86 in this hospital.

We were unable to verify your information on patients who died outside of the hospital within 30 days of discharge.

In reviewing the report in detail, we did not find the format of the report refined enough to be meaningful and significant in evaluating the overall quality of care given the patient.

Sincerely,


Bill Langford
Executive Director

BL:ms

Attachment

College and Western Streets
Conway, Arkansas 72032
(501) 325-7831

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.



DELTA MEMORIAL HOSPITAL

P. O. BOX 126

DUMAS, ARKANSAS 71639

PHONE: 501-382-4303

S. HOWARD JOHNSON, F.A.C.H.A.
Administrator

October 28, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

We have reviewed the data and our mortality rate is well within the limits established by HCFA.

The mortality rate in no way reflects quality care.

Sincerely,


Howard Johnson
Administrator

HJ/pm

Medicare Provider # 04053

**GRAVETTE
MEDICAL
CENTER
HOSPITAL**



GRAVETTE, ARKANSAS 72736
PHONE AC (501) 787-5291

October 21, 1987

William L. Roper, M. D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

RE: Hospital Mortality Report
Hospital 040075

Dear Sir:

We have carefully reviewed the mortality report for our hospital and have enclosed the corrections to be made on our individual report.

We are anxiously awaiting the final publication in December.

Respectfully,


John R. Rhine
Administrator

JRR/re
Enclosure

Better Hospitals Build Better Communities

CORRECTIONS TO MADE ON MORTALITY STUDY:

RE: HOSPITAL 040075

HIC# [REDACTED]

Wrong principal diagnosis on data.
It should be 431 (CVA) not 205.0 (Leukemia)

HIC# [REDACTED]

Patient's age on data is 079
Should be 089

HIC# [REDACTED]

Wrong principal diagnosis on data
Should be 410.4 (MI) not 427.41 (V-Fib.)

HIC# [REDACTED]

Admission and discharge date on data is wrong. 1/12/86 - 1/23/86 are previous admission dates. Should be admission and discharge dates of 2/2/86 - 2/3/86 and date of death is wrong - should be 2/3/86.

HIC# [REDACTED]

Wrong principal diagnosis on data.
Should be 410.4 (MI) not 414.0 (CAD)

Harris Hospital
An Affiliate of National Healthcare, Inc.

1205 McLain Street
Newport, Arkansas 72112
501/523-8911



October 26, 1987

William L. Roper, MD
Administrator
Health Care Financing Administration
Washington, DC 20201

Dear Dr. Roper:

The information submitted to us has been reviewed and has
been found to be accurate.

Thank you for including the hospital's input in this
publication.

Sincerely,

A handwritten signature in dark ink, appearing to read "James P. Seward, Jr." with a stylized flourish at the end.

James P. Seward, Jr.
Executive Director

JPS/mg



George W. Johnson
Administrator

October 26, 1987

Medicare Provider No. 04-0031

To Whom It May Concern

The actual mortality rates calculated by Health Care Financing Administration for Huntsville Memorial Hospital were within the range of the predicted mortality rates with the exception of the diagnostic category of cancer. This was expected since Huntsville Memorial Hospital has implemented two programs which deal with terminally ill cancer patients.

The first of these programs is home health services. Many cancer patients are referred to this service after all treatments for cancer have been exhausted. These terminally ill patients are cared for at home by Huntsville Memorial Hospital home health staff and are admitted to the hospital when close to death. Huntsville Memorial Hospital is the only provider of this service in the immediate area.

The Second program, which Huntsville Memorial Hospital is the only provider, is the **Swing Bed** program. This medicare design program allows a hospital to provide long term skill nursing care after a mandated three day acute care stay. These patients are admitted to the hospital, many from surrounding hospitals, to receive terminal care where the expected outcome of the admission/discharge is death.

The above two programs account for the increased mortality rate for the diagnostic category of cancer. Huntsville Memorial Hospital has an on going quality assurance program and the quality assurance committee will continue to monitor mortality rates for Huntsville Memorial Hospital.

PHILLIPS & EDGEWOOD PLACE • P. O. DRAWER E
HUNTSVILLE, ARKANSAS 72740
501-738-2033

**LAWRENCE MEMORIAL HOSPITAL
LAWRENCE HALL**

1309 Highway 25 West
WALNUT RIDGE, ARKANSAS 72476
Phone 501-886-1200

October 9, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

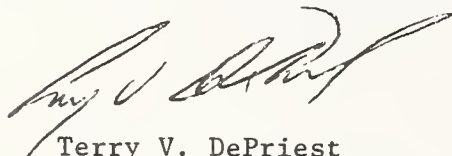
We are in receipt of the hospital mortality information you forwarded to us on September 21, 1987. Our Chief of Surgery has completed a mortality review for each of these cases and the following items of note were found.

We had one case of sepsis and one case of severe trauma in the 12 month period that was reviewed. Since both of these cases are now deceased, that gave us a 100% death rate for these two categories. We feel that one case is not statistically significant and, therefore, such small numbers should not be included in your statistical analysis. It is my belief in the future that your review should be confined to areas which have sufficient numbers to insure statistical significance before making judgments on facilities.

I appreciate your interest and time in reading this letter and if I may provide assistance or answer any questions, please feel free to advise me.

Sincerely,

LAWRENCE MEMORIAL HOSPITAL



Terry V. DePriest
Administrator

McGehee---Desha County Hospital

P.O. BOX 351

McGEHEE, ARKANSAS 71654

TALMADGE ROBERTSON, F.A.C.H.E.
Administrator

October 16, 1987

Department Of Human Services
Health Care Financing Administration
6325 Security Blvd.
Baltimore, Maryland 21207

Gentlemen:

Our critique and rebuttal of the mortality information that was mailed to us for review is as follows:

PATIENT #1. Patient was in this hospital 3 times before his death of Carcinoma of lung. He was also in hospital in Mississippi. His care was given by Home Health between these admissions. Patient 82 years of age, also had intractable pain, malnutrition, urinary tract infection.

PATIENT #2. 75 years of age. Adenocarcinoma colon for 3 years with metastasis, dehydration, colectomy, malnutrition.

PATIENT # 3. 79 years of age, from local skilled nursing home, only one in this area, so all patients flow in to them and on to us when they are unable to treat longer. Had acute hepatic tumor, acute renal failure, acute gastric obstruction.

PATIENT # 4. Patient had Carcinoma of lungs, acute bronchitis, acute pneumonia. Had acute hemoptysis and acute respiratory distress, had respiratory arrest. Long history of heavy smoker, thin, malnourished.

PATIENT # 5. Patient admitted with pneumonia with pleural effusion, CA of breast with metastasis, malnutrition. Patient had Carcinoma for several years.

Diagnosis CA -6 patients-5 deaths-83% of these five, three were over age 75. All but one had been diagnosed previously as having terminal condition. The other patient was a nursing home patient who was 79 years old. All had either metastasis or complications. All were malnourished.

PATIENT # 6. 93 year old admitted comatose-appeared to have had recent stroke, felt to be cerebral hemorrhage. Never regained consciousness.

PATIENT # 7. 69 year old, admitted with symptoms of acute CVA. Admitted to MCU. Also had organic heart dz., Hypothyroidism, Hypertension and GI bleeding by history. Upon admission patient was found to have complete right side paralysis and aphagia. Could not tolerate oral feedings because unable to swallow. Condition gradually deteriorated and died of acute CVA.

PATIENT # 8. 78 year old admitted thru ER. Had acute CVA at home and experienced acute right side paralysis. Was brought to hospital after becoming comatose. Also had severe uncontrolled hypertension and acute aspiration pneumonia. Cause of death- Acute CVA.

PATIENT # 9. 72 year old brought in thru ER in acute respiratory distress. Respiratory resuscitation began immediately and endotracheal tube inserted. Patient remained comatose and died of acute CVA after having complications of acute cardiac arrhythmia, COPD and acute respiratory arrest again 2 days after admission, when he expired.

PATIENT # 10. 78 year old admitted with acute vomiting and severe hypertension and extremely lethargic. Developed acute CHF and acute pneumonia. Also had UGI bleeding and had to have NG tube inserted because unable to eat, before death.

PATIENT # 11. 73 year old, admitted with acute UGI hemorrhage which was secondary to CA of small intestine with (approx. 2 1/2 yrs), metastasis to colon, lung and pancreas and liver condition had worsened recently and was in constant pain in abdomen. Hgb. was low initially and even after transfusion continued to drop. Patient had refused cancer treatments.

PATIENT # 12. 84 year old admitted thru ER from nursing home, was brought to hospital when nursing home personnel noticed change in mental status and loss of appetite. History of Staph infection and numerous decubitus ulcers which were being treated at the nursing home. History of CA of stomach and had had previous surgery and colostomy was present at time of admission. Had many complications such as UTI, obstructive uropathy and diverticulosis. Obtained surgical consult-patient died of probable acute MI on 4th day of admission.

PATIENT # 13. 81 year old who had been on Swing-bed after being hospitalized for CHF, organic brain syndrome and chronic UTI. Condition deteriorated, UTI became more acute and grew an organism so she was admitted back to acute care. Developed renal failure and Recto/Vaginal fistula. Had weight loss of 55 1/2 lbs. over the past year, was very weak and nutritional status was poor. Also had complication of pneumonia.

PATIENT # 14. 92 year old admitted with diagnosis of CHF. Very weak, tachypneic. Complication of organic heart dz., UTI, seizure disorder and blindness.

PATIENT # 15. 97 year old admitted thru ER with SOB and diaphoresis. Has history of being treated for CHF, CVA and hypertension. Currently diagnosed as having acute anteroseptal MI. Dehydrated on admission.

PATIENT # 16. 86 year old admitted after having chest pain radiating to left arm for several days. Was placed on MCU and treated with O2. Bagged for 2 hours due to respiratory arrest, responded at first, then there was less and less response until all vital signs ceased. Had previously been treated for cardiac condition and hypertension.

PATIENT # 17. 66 year old admitted thru ER complaining of sudden onset of acute chest pain and weakness. Irregular heart rate. Developed acute ventricular arrhythmia and went into cardiogenic shock.

PATIENT # 18. 82 year old admitted thru ER after being found unconscious in his home by a neighbor. Was cold, had been living alone in house with no heat (in December) was suffering from exposure. Remained comatose and went into respiratory and cardiac arrest. Complications of pneumonia and CHF.

PATIENT # 19. 92 year old admitted thru ER with acute substernal chest pain, SOB, diaphoresis, very weak. Prognosis on admission was very poor. Acute inferior MI. History of coronary disease, ASHD and cerebral AS disease.

PATIENT #20. 74 year old admitted very confused, weak, poor skin turgor. Wife stated had had acute seizure at home and that this was the 4th time in 30 days he had had a seizure and been taken to another hospital by ambulance. Never been a patient in this hospital.

PATIENT #21. 75 year old admitted with chest pain and SOB, complications of CHF, pneumonia and chronic obstructive pulmonary disease. Principal diagnosis was anteroseptal MI. Responded poorly to treatment.

PATIENT #22. 71 year old admitted with severe COPD and ASHD. Now has severe chest pain and SOB, color pale. Principal diagnosis is acute anterior MI with complications of CHF and IDDM

PATIENT #23. 72 year old admitted pale, weak, in acute distress. Past history of hypertension, OHD with aortic valvular disease. Acute inferior MI complicated by CHF and aortic valvular disease.

PATIENT #24. 89 year old treated here many times for various illnesses. Long-standing OHD, peripheral vascular disease and chronic CHF. Responsive ONLY to deep pain. Acute pneumonia complicated by CHF.

PATIENT #25. 97 year old admitted from nursing home. Pneumonia complicated by renal dysfunction, probably acute MI, arthritis and advanced age.

PATIENT #26. 93 year old-longstanding organic heart disease and in a weakened condition since having cardiac arrest at another hospital several months previously. Poor nutritional status, responsive ONLY TO DEEP PAIN. Pneumonia complicated by gastrointestinal bleeding and dehydration and respiratory failure and COPD.

PATIENT #27. 74 year old with acute vomiting, dehydrated, malnourished. Longstanding history of alcoholism. Also has leukemia. Principal diagnosis was pneumonia complicated by acute alcoholic gastritis and acute metabolic acidosis (which was cause of death).

PATIENT #28. 66 year old. Although principal diagnosis was shock-2° to blood loss-patient had CA of ovary and was receiving chemotherapy prior to admission. Brought to hospital because of acute weakness and vaginal hemorrhage.

PATIENT #29. 77 year old admitted to Swing-bed for continued treatment for decubitus ulcers. Also, has metastatic CA-primary right breast and right hemiplegia 2° to brain metastasis. On admission was very weak and emaciated. Condition gradually deteriorated.

- * It is difficult to respond to the mortality rates that HCFA has reported for our hospital-primarily because of the discrepancy between the number of "cases" included in the HCFA analysis and the actual number of Medicare beneficiaries that were treated in this hospital in 1986. Even allowing for the fact that only one admission per patient, per year, was included in this report the numbers differ significantly, and this would make a difference in our actual mortality rate overall and within each category. For instance, in the diagnostic category "Cancer", HCFA reports our hospital to have treated 6 cases for the year with 5 of these patients having died here. Our records show that 12 cases (this is allowing only one admission per patient) with 8 of these patients expired. This brings our hospital's mortality rate down from 83% to 67% (according to our records).

There are several other factors to be considered here also. One of these is age. The average of patients who expired in our hospital is 77, and of the 35 who died, 29 were over the age of 70. Some of these patients were in here shortly before death. Others had been diagnosed as having terminal diseases and were admitted here in the acute stage of illness in order to be close to their families. Some of these had been receiving treatment in their homes from our Home Health Agency in the earlier stages of their disease. The MAJORITY OF PATIENTS ADMITTED AND TREATED AT MCGEHEE DESHA COUNTY HOSPITAL are Medicare patients, most of whom are suffering from chronic illnesses. Most of these patients are also treated for complicating conditions or comorbid conditions, which are not considered by HCFA in preparing the analysis. Upon review of the records, all of the patients who died here in the Cancer category and those in the Severe Acute Heart Disease category (both high-risk categories) had complicating or comorbid conditions.

When all of these things are taken into consideration, we feel the effectiveness of HCFA's study is limited. This type of study is probably necessary, but should not be considered as a basis for judging the quality of care given at our hospital. Publication of this data could be more harmful than helpful due to the fact that the general public will not understand all the factors involved in determining the actual mortality rates nor will they know all things that should be considered in deciding the significance of the report.

Part of our Quality Assurance Program is evaluation of all deaths every month, so we are aware of the fact that these patients receive good quality care.

Sincerely,

Talmadge Robertson
Talmadge Robertson, F.A.C.H.E.
Administrator

TR/bw

MEDICAL CENTER OF CALICO ROCK, INC.

CALICO ROCK, ARKANSAS 72519
CLINIC PHONE 297-3728
HOSPITAL PHONE 297-3726

"Blessed be God . . . who comforteth us in all our afflictions." II Corinthians 1:3, 4.

September 25, 1987

William L. Roper, M.D. Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dr. Roper:

In reply to your recently published Mortality Study. We feel to publish these statistics nationally would disillusion the public about short term acute care facilities.

The percentage of mortalities on paper looks unreal. Our number of patients and deaths is small and, therefore, distorts the statistics.

We have an average of 63 percent medicare patients and the average age of those medicare patients is 77 years old. Most people would not even question the natural deaths of these patients if it were not called to their attention.

In the study, we only had a 17 percent mortality rate. For a small hospital located in a retirement area, this percentage is not large. All of the actual mortality rates fell within the ranges of the predicted rates and none went over the predictions.

We appreciate the opportunity to be able to comment on these studies before publication. If more information is needed please write and ask.

Sincerely,



John L. Grasse, Administrator

JLG/kb

October 23, 1987

William Roper, M.D.
Administrator, HCFA
Health and Quality Bureau
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

AMI Medical Park Hospital is a progressive 75 bed acute care facility serving the people of rural Southwest Arkansas, with a total commitment to quality patient care. The medical and professional staff utilize comprehensive quality review mechanisms to evaluate the care received by each and every patient admitted to this facility. In addition, each patient who expires at this facility is subject to a complete review regarding medical management and overall care. The quality assurance process is a continuing, aggressive program to assure that the highest level of care possible is delivered to our patients. Medical Park Hospital is accredited by The Joint Commission on Hospital Accreditation and meets all State and Federal licensure requirements.

The hospital specific mortality data reported by the HCFA has been reviewed by our hospital staff and is considered accurate with one exception. However, the use of mortality rates cannot be directly correlated with quality care.

The data used by HCFA indicate that a total of 63 Medicare patients admitted to Medical Park Hospital died within 30 days of admission. Of these patients, ten actually expired outside this facility and one at another facility. Our records indicate that we treated well in excess of 700 Medicare patients while the data indicate approximately 441 patients. This discrepancy reflects multiple admissions of individual beneficiaries to the same or different hospitals during the reporting period.

Medical Park Hospital fell within the predicted mortality range for all categories; however, in several instances not enough patients were in a reported category to make the statistics valid.

The medical and professional staff at Medical Park Hospital will continue to review all mortality cases for quality and appropriateness of care rendered to the individual patient. A careful analysis of this information is utilized to identify opportunities to improve

Letter To: William Roper, M.D.
Page No: Two
Date: October 23, 1987



patient care. The HCFA data will be incorporated as a part of our quality assurance program for the purposes of trending analysis.

Any questions regarding this information may be addressed to AMI Medical Park Hospital, 2001 South Main, Hope, AR 71801, attention Administration.

Sincerely,

A handwritten signature in cursive script that reads "Donald G. Carney".

Donald G. Carney
Chief Executive Officer

DGC:ns

COMMENTS ON THE 1986 HCFA MORTALITY DATA
Baptist Medical System
Little Rock, Arkansas

The Baptist Medical System includes three acute care hospitals, Baptist Medical Center is a 739-bed tertiary care hospital located in Little Rock; Memorial Hospital is a 260-bed community hospital in North Little Rock; Twin Rivers Medical Center is a 57-bed community hospital in Arkadelphia.

Baptist Medical System hospitals strive to be "centers of excellence." Providing quality care to our patients is of utmost concern to the governing board, medical staffs and management. We recognize the value of mortality data in the identification of potential quality problems. Periodically (monthly, quarterly, etc.), we evaluate data for trends or potential problems. If a case is questionable, we don't hesitate to take action to correct the problem and prevent further occurrences.

Although the reported data indicates that we are within (or below) the predicted range in all categories, we strongly disagree with the implication that this data can be used as a measure of quality.

Our concerns are based on the following:

1. We cannot verify the accuracy of HCFA statistics on deaths after discharge because we do not have access to the Social Security data used.
2. We received an inadequate description of the methodology used to calculate expected mortality rates. We cannot duplicate it for our own use.
3. THE MODEL HAS NOT BEEN VALIDATED. The reliability of the mode is unknown, but appears limited.
4. The patient's severity of illness is not taken into account. A hospital's mortality rate may be significantly impacted by difference in case mix.
5. A higher than average mortality rate does not necessarily mean poorer performance. A hospital may specialize in high risk cardiac and trauma surgery, or have large number of chronic lung disease patients requiring long term ventilator use, or a hospice service.

6. Attributing a patient's death to an individual hospital based solely on the fact that the patient died within 30 days of admission does not measure the quality of care provided in that facility or by the attending physician. The statistics do not take into consideration noncoded contributing diseases or complications due to lack of space on the bill. Other factors which must be considered are:
 - A. The use of medical services early in the course of the disease causing a timely diagnosis and admission for treatment.
 - B. The appropriateness of outpatient services provided.
 - C. The availability and quality of post hospital services and treatment.
 - D. The general health status of the patient, stage of illness and psychological condition.
 - E. Social factors, such as family support and dynamics.
7. There are discrepancies between the hospital's abstracted data, the local peer review organization's data and the HCFA data provided. For example, the data by HCFA indicate that a total of 5594 Medicare patients were last admitted in 1986 to Baptist Medical Center. We have no way to readily verify the number of cases, since our data is based on all Medicare admissions during 1986, which was 9117. Of those 5594 cases, 436 deaths within 30 days of admission were reported. We were able to verify only 431 of those deaths. HCFA also reported that 63 of the deaths occurred after discharge. Our records indicate that 3 of the reported deaths after discharge actually occurred in Baptist Medical Center, decreasing the number to 60.
8. The summary of mortality data does not include critical information such as age (90% of patients may be over 80 years old).

While we recognize the need to provide the consumer with valid and useful information on the quality of hospital care, we believe that better measures are needed. We are currently working with the American Hospital Association and other organizations, including the Joint Commission on Accreditation of Hospitals, to develop methods of evaluating hospital quality nationwide that rely on measures other than mortality rates.

HOSPITAL ID NUMBERS

BAPTIST MEDICAL CENTER = 040114
MEMORIAL HOSPITAL = 040036
TWIN RIVERS MEDICAL CENTER = 040066

MERCY HOSPITAL of Scott County Pinewood Nursing Home

Box Q, Waldron, Arkansas 72958
(501) 637-4135

COMMENTS ON THE HCFA MORTALITY DATA Mercy Hospital of Scott County; Waldron, Arkansas (MHSC)

Medicare Billing Number: 040040

Data Verification:

MHSC is within the HCFA "predicted" mortality ranges in all categories, and in total. The data used by HCFA indicates that from a total of 211 Medicare beneficiaries who received care at MHSC in 1986, 34 of these individuals died within 30 days of admission. Of these, 29 died while still a patient of the hospital, and 5 died after discharge, but within 30 days of admission to MHSC. It would be most difficult and intrusive to verify the status of the individuals shown by HCFA to have died after discharge, as information concerning death after discharge is not included in the patient's medical record. Our records indicate that 373 Medicare admissions occurred in 1986. Presumably the discrepancy reflects multiple admissions of individual beneficiaries to MHSC.

Unique Services

Mercy Hospital of Scott County is a small rural facility serving a population of older citizens with many chronic diseases and multiple illnesses. Many patients are transferred to nursing homes and to larger hospital facilities for further care.

Results of Medicare Record Review and Reporting Errors:

Of the 5 deaths which occurred outside our facility, 2 were transferred to other hospital facilities where they expired. This reduces the Actual Mortality Rate in Diagnostic Category HS "Severe Acute Heart Disease" to 23% rather than 31% as shown by HCFA and reduces the Actual Mortality Rate in Diagnostic Category HL "Low-Risk Heart Disease" to 0% rather than 5% as shown by HCFA.

In the absence of a comprehensive measure of Severity-of-Illness, the HCFA method of analysis is misleading when applied at the institutional level. For example, our records indicate that of the 29 Medicare Inpatient deaths, 12 (41%) were cases in which "Do Not Resuscitate" orders were in effect at the patient's or family's request.

Taking into consideration, the above 2 corrections, MHSC's corrected inhospital deaths were 29 and post discharge deaths were 3, giving a total of 32 for the 1986 reporting period. As a result of these corrections, our overall mortality rate for 1986 was 15%, not 16% as shown by HCFA.

All of these 1986 deaths were reviewed by our Medical Staff at the Medical Care Evaluation Committee meetings, so we have gained no operational benefit from the release of this information.

Sincerely,

Sister Donald Mary Lynch RSM, FACHE
Sister Donald Mary Lynch, RSM, FACHE
Chief Administrative Officer



Under the management of ST. EDWARD MERCY MEDICAL CENTER Fort Smith, Arkansas 72903

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

METHODIST HOSPITAL
OF JONESBORO



3024 Stadium Boulevard
Jonesboro, AR 72401
501-972-7000
Call Visitor Center

501-972

October 6, 1987

William L. Roper, MD, Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

RE: Methodist Hospital of Jonesboro
Medicare Provider Number 04-0118

Dear Dr. Roper

I have reviewed your letter of September 24, 1987, and the enclosed mortality data. There appears to be serious errors in your information as compared to the actual data at Methodist Hospital of Jonesboro. Your computer report indicates a total of 1148 Medicare admissions in 1986 when Methodist Hospital of Jonesboro actually experienced 1855 admissions in 1986. The total mortalities of 125 as reported in your data appears to be correct. It should be noted that 28 of the 125 patients died, after discharge, somewhere other than Methodist Hospital of Jonesboro. It would appear to me that the overall mortality rate for Methodist Hospital of Jonesboro should be 6.8%, calculated by dividing 125 mortalities by 1855 admissions for 1986, which yields a 6.8% mortality rate as compared to the 11% mortality rate for all causes reported in your data. Furthermore, it appears that your total number of cases for each diagnostic category probably is in error since you under-reported the total number of admissions for Methodist Hospital of Jonesboro by 61.6% for 1986.

In summary, I feel that there are serious errors in the data for Methodist Hospital of Jonesboro and that appropriate corrections should be made before publishing this data.

Sincerely

Philip H. Walkley, Jr., FACHE
Administrator

PHWjr:kh



MISSISSIPPI COUNTY HOSPITAL
BLYTHEVILLE

Division & Highland Streets
P.O. Box 108
Blytheville, Arkansas 72315

October 27, 1987

Health Care Financing Administration
P.O. Box 26684
Baltimore, Maryland 21207

Dear Sir:

According to the HCFA statistical analysis, Mississippi County Hospital, Blytheville appears to be outside the predicted range in the disease category of Severe Chronic Heart Disease. The hospital scored 35% in relation to HCFA's range of predicted mortality rates of 12% to 33% for this particular category. Mississippi County Hospital Blytheville is a 168 acute care facility approved by JCAH.

The Administration and the medical staff working collaboratively with the Board of Governors, have established a planned and systematic quality assurance program which monitors the professional activities of the medical staff and other health care professionals.

A detailed review of the HCFA mortality data for Severe Chronic Heart Disease was done. Findings demonstrated that these patients were severely or terminally ill at the time of admission. No quality problems were encountered in the review of this data.

Sincerely,



John Boone
Administrator

Enclosure

MISSISSIPPI COUNTY HOSPITAL
OSCEOLA

Division & Highland Sts.
P.O. Box 108
Blytheville, Arkansas 72315

October 27, 1987

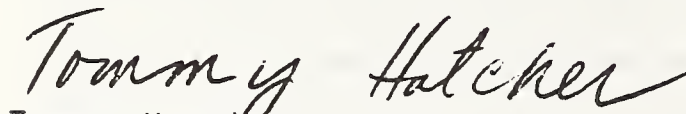
Health Care Financing Administration
P.O. Box 26684
Baltimore, Maryland 21207

Dear Sir:

We have received the data on Mortality Statistics provided by the Health Care Financing Administration. This data has been reviewed and evaluated. Mississippi County Hospital - Osceola mortality data is within the predicted ranges.

Mississippi County Hospital - Osceola is an 88 acute care hospital which provides service to a community of 8,000.

Mississippi County Hospital is accredited by the Joint Commission on Accreditation of Health Care Organizations. One of the major requirements for accreditation is a Quality Assurance Plan and Program approved by the Hospital and Medical Staff. The quality of care provided at our hospital is assessed through this program. Mortality Review is part of this program and is done by the Medical Staff at our hospital. No quality problems have been identified.


Tommy Hatcher
Administrator

TH/vh/416



NORTH LOGAN MEMORIAL HOSPITAL - PARIS

COMMENTS ON THE HCFA MORTALITY DATA

PARIS, ARKANSAS 72855

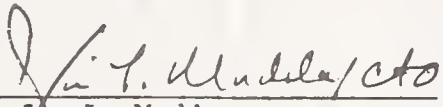
The data used by HCFA indicate that from a total of 180 Medicare beneficiaries who received care at North Logan Mercy Hospital in 1986, 28 of these individuals died within 30 days of admission. Of these 22 died while still a patient at the hospital, and 6 died after discharge, or within 30 days of admission to North Logan Mercy Hospital. It would be most difficult and intrusive to verify the status of the individuals shown by HCFA to have died after discharge, as information concerning death after discharge is not included in the patient's medical record. Our own records indicate that 287 Medicare admissions occurred in 1986. Presumably the discrepancy reflects multiple admissions of individual beneficiaries at North Logan Mercy Hospital.

In one of the diagnostic categories (SE ; Sepsis) North Logan Mercy Hospital's actual mortality rate falls outside the range predicted by HCFA. After correction, (see below), our actual mortality rate for this category was 0%. North Logan Mercy Hospital was within the HCFA predicted mortality ranges in all categories, and in total for 1986.

Under diagnostic category (SE;Sepsis) the HCFA mortality rate for North Logan Mercy Hospital is shown as 100%. We treated only one Medicare beneficiary in this category during 1986, and one in-hospital death was attributed to us by HCFA. Our review shows that this one case of sepsis was a person who was actually transferred alive to another acute care hospital for continued care as North Logan Mercy Hospital is a 20 bed rural health care facility. Our followup with the receiving hospital verified that the patient expired at the receiving acute care hospital. Our recalculation of the actual mortality rate for this category is then 0%.

Under the diagnostic category (HS;Severe Acute Heart Disease) actual mortality rate for North Logan Mercy Hospital was shown as 33% which does fall within the range of the predicted mortality rate. Our review shows that one of the patients in this category was transferred to another acute care hospital for continued patient care as North Logan Mercy Hospital is a 20 bed rural health facility. Followup with the receiving facility verified that the patient expired while receiving care at that acute care hospital. Our recalculation of the actual mortality rate for this category is then 25%.

Taking into consideration the above two corrections, North Logan's corrected in-hospital deaths was 21 and post discharge deaths was 5 , giving a total of 26 for the 1986 reporting period. As a result of these corrections, our overall mortality rate for 1986 was 14%, not 16% as shown by HCFA.



Jim L. Maddox
Chief Administrative Officer
North Logan Mercy Hospital

UNDER THE MANAGEMENT OF NORTH LOGAN MERCY HOSPITAL, PARIS, ARKANSAS

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

NORTH LOGAN MERCY HOSPITAL, PARIS, ARKANSAS

Worksheet 1: Analysis of Reporting Errors

Diagnostic Category	Deaths Reported by HCFA		Deaths Verified by Hospital*	
	In-hospital	Post-hospital	In-hospital	Post-hospital
CA -- Cancer	5	2	5	2
CE -- Cerebrovascular Accidents		1		1
GC -- Gastrointestinal Catastrophes	2		2	
GI -- Gastrointestinal Disease				
GU -- Urologic Disease				
GY -- Gynecologic Disease				
HL -- Low Risk Heart Disease	1		1	
HM -- Severe Chronic Heart Disease	2	1	2	1
HS -- Severe Acute Heart Disease	2	1	2	0
ME -- Metabolic/Electrolyte Disturbances				
OP -- Orthopedic Disorders				
PN -- Pulmonary Disease	6		6	
RN -- Renal Disease				
SE -- Sepsis	1		0	
TR -- Severe Trauma				
OP -- Ophthalmologic Disease				
UN -- Other Diagnoses	3	1	3	1
Total -- All Categories	22	6	21	5

NOTES: In the Deaths reported by HCFA, tabulate the number of deaths assigned to each diagnostic category on the individual care listing. In-hospital deaths are those patients whose date of discharge is the same as the date of death; post-hospital deaths are those patients whose date of death is after the date of discharge. Verified deaths should include those patients who are known to have died or whose status 30-days after discharge from the hospital cannot be determined. Verified deaths should also exclude patients that the hospital does not believe were ever admitted to the hospital.

NORTH LOGAN MERCY HOSPITAL
PARIS, ARKANSAS

HOSPITAL = 040124

<u>DIAGNOSTIC CATEGORY</u>	<u>CASES</u>	<u>ACTUAL MORTALITY RATES</u>	<u>RANGE OF PREDICTED MORTALITY RATES</u>
All Causes	180	14 %	9 to 21%
CA - Cancer	17	41 %	17 to 61%
CE - Cerebrovascular Accidents	5	20 %	4 to 71%
GC - Gastrointestinal Catastrophies	6	33 %	3 to 66%
GI - Gastrointestinal disease	11	0 %	0 to 51%
GU - Urologic disease	7	0 %	0 to 71%
GY - Gynecologic disease	2	0 %	0 to 100%
HL - Low risk heart disease	19	5 %	0 to 29%
HM - Severe chronic heart disease	15	20 %	6 to 46%
HS - Severe acute heart disease	8	25 %	16 to 73%
ME - Metabolic/electrolyte disturbances	2	0 %	0 to 89%
OP - Orthopedic Disorders	5	0 %	0 to 99%
PN - Pulmonary Disease	14	43 %	7 to 50%
RN - Renal disease	4	0 %	2 to 76%
SE - Sepsis	0	0 %	0 to 97%
TR - Severe trauma	2	0 %	0 to 96%

We would formally like to request that these corrections be made prior to publication.

Jim L. Maddox
Chief Administrative Officer
North Logan Mercy Hospital

Piggott Community Hospital

1206 Highway 62 West

Piggott, Arkansas 72454

October 26, 1987

William L. Roper, MD, Administrator
Health Care Financing Administration
Washington, D.C. 20201

RE: Comments on the HCFA Mortality Data
Piggott Community Hospital
Piggott, Arkansas

Dear Dr. Roper:

The data used by Health Care Financing Administration indicate that a total of 58 Medicare patients admitted to the Piggott Community Hospital died within 30 days of admission. Of these, 47 died while still a patient of the hospital, while 11 died after discharge. Our own records indicate that 57 Medicare admissions occurred in 1986. Presumably, the discrepancy reflects 1 admission in 1985. Our own records also indicate that of the 58 Medicare patients who died within 30 days of admission while still an inpatient, 11 were still alive at the time of discharge. It is impossible to determine if the 11 patients dying after discharge who were in fact alive, have been placed in the correct diagnostic category as information concerning death after discharge is not included in the patient's medical record. We are enclosing an Analysis of Reporting Errors to verify the report received from Health Care Financing Administration.

Without detailed information concerning the billing data available to Health Care Financing Administration in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

It should be taken into consideration that the average age of the patients listed in the report is 80 years. Also, of the 58 patients listed, 21 were 85 years old or older. Another factor to be taken into consideration is the use of the Swing Bed facility of the hospital for care of terminally ill patients. There were 9 deaths occurring in this area of the hospital and certainly these deaths were not unexpected. Also, there were 17 of the deaths occurring within 48 hours of admission. The status of these patients at the time of admission was such that death could have been anticipated at that time. Another factor is the requirement of the PRO regarding sequencing of the diagnoses. This results in the final diagnosis not clearly reflecting the cause of death of a patient. An example of this is a patient admitted to the hospital for treatment of an urinary tract infection who had Metastatic Carcinoma from the Ovary which actually caused the death. Your data does not reflect such occurrences. Also, there were 4 of the deaths occurring when the patients were transferred back to the acute care area of the hospital when they had been treated in Swing Bed for several

William L. Roper, MD
Page 2

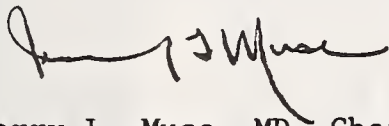
October 26, 1987

days. Statistically, this occurs quite frequently. In 29 of the deaths, the patient was either terminal upon admission or the condition became such as the patient or the patient's family requested that no code be performed on the patient.

I feel the above comments should be taken into consideration and very seriously in any statment released to the public.

Very sincerely yours,

PIGGOTT COMMUNITY HOSPITAL



Jerry L. Muse, MD, Chairman
Utilization Review Committee

cc. Betty J. Reams, Executive Director
Piggott Community Hospital Medical Staff
Enclosure

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Worksheet 1: Analysis of Reporting E

Diagnostic Category	Deaths Reported by HCFA		Deaths Verified by Hospital*	
	In-hospital	Post-hospital	In-hospital	Post-hospital
CA -- Cancer	6	1	6	1
CE -- Cerebrovascular Accidents	3		3	
GC -- Gastrointestinal Catastrophes				
GI -- Gastrointestinal Disease	2		2	
GU -- Urologic Disease				
GY -- Gynecologic Disease				
HL -- Low Risk Heart Disease	2	1	2	1
HM -- Severe Chronic Heart Disease	4		4	
HS -- Severe Acute Heart Disease	7	2	7	2
ME -- Metabolic/Electrolyte Disturbances				
OP -- Orthopedic Disorders				
PN -- Pulmonary Disease	5	4	5	4
RN -- Renal Disease	3	1	3	1
SE -- Sepsis	3	1	3	1
TR -- Severe Trauma				
OP -- Ophthalmologic Disease				
UN -- Other Diagnoses	12	1	12	1
*Total -- All Categories	47	11	47	11

NOTES: In the Deaths reported by HCFA, tabulate the number of deaths assigned to each diagnostic category on the individual care listing. In-hospital deaths are those patients whose date of discharge is the same as the date of death; post-hospital deaths are those patients whose date of death is after the date of discharge. Verified deaths should include those patients who are known to have died or whose status 30-days after discharge from the hospital cannot be determined. Verified deaths should also exclude patients that the hospital does not believe were ever admitted to the hospital.

*Please note that this only verifies that the patients listed in each of the above categories is dead, but does not necessarily verify that the category listed was the cause of death.

Randolph County Medical Center

A National Healthcare Affiliate

2801 Medical Center Drive
Pocahontas, Arkansas 72455
501/892-4511



October 15, 1987

William L. Roper, M.D.
Administrator
Department of Health and Human Services
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

I have reviewed the mortality information which you recently sent to my attention. I have only one area of concern and that is relating to Patient ID Number [REDACTED]. This patient was here for only one day and was shipped to a larger institution and died at that institution. This patient has been charged to this facility instead of the facility to which he was transferred.

Even though the mortality rate at Randolph County Medical Center falls within the predicted range, I have a number of concerns about this information. Randolph County Medical Center is located in an area that has an older population and a shortage of nursing home beds. This shortage is actually that there are no nursing home beds available. So as you review my report, you see a number of patients admitted just prior to death. I understand the Department's desire to establish quality health care, but with certain problems such as I have mentioned, this information should be modified to reflect these problem areas.

Sincerely,

A handwritten signature in dark ink, appearing to read "Hank Fender". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Hank Fender
Executive Director

HF/cl

cc: Linda Cooley



Saline Memorial Hospital

North East at McNeil Streets
Benton, Arkansas 72015
Telephones - Benton: 776-0611
Little Rock: 847-0613

October 27, 1987

William L. Roper, M.D.
Administrator
Department of Health and Human Services
Health Care Financing Administration
P. O. Box 26684
Baltimore, MD 21207

SUBJECT: Saline Memorial Hospital
Medicare Provider Number 040084

Dear Dr. Roper:

Saline Memorial Hospital is proud to acknowledge that in all diagnostic categories, the actual mortality rate is below the "predicted" range as noted by the HCFA. Although we are represented in a favorable manner, the information is somewhat misleading with many facts not represented. We would like to share some of our concerns about the validity of the mortality data, which may be causing unnecessary anxiety to millions of healthcare recipients. It should be noted that HCFA does not recommend that the information be used to judge quality of care or be used to compare hospitals, as the statistics have not been proven valid.

Please see below some of the important points which you should be aware:

1. It is historically factual that human beings have a finite life expectancy. The average age of the patients contained in our mortality statistics is 79+ years of age. This is well beyond the current life expectancy of 74.9 years, and is considerably beyond their life expectancy when they were born, which was 47.6 years. Therefore, it is not unusual for these patients to have died.
2. It is also factual that as human beings reach the final stages of their lives, many develop multiple health related problems. Almost all of these patients had multiple, coexisting medical problems that complicated, contributed to, or caused the death. In fact, a random review of these cases revealed that each patient had an average of three major organ or system disorders that directly influenced the patient's demise.

3. The mortality information strongly implies that the cause of death was due to the principle reason that necessitated the hospitalization. In some cases, the cause of death was totally unrelated to the disease for which the patient was hospitalized. In fact, one patient took his own life after discharge from the hospital.
4. A random review of records also revealed that 90% of the patients had family concurrence for orders not to perform any extraordinary medical intervention that would prolong the patient's suffering.
5. Approximately 25% of the patients identified in the study died after their discharge from the hospital. Many of these patients and/or their families requested discharge because death was expected. Once a patient leaves the hospital, there are many factors which affect the patient's health, such as the home environment, family support, adherence to discharge instructions, et cetera. Some patients prefer to die in the privacy of their own home.
6. Some of the patients listed in Saline Memorial Hospital's mortality statistics were transferred from this hospital to another acute care hospital. We can only assume that these patients died at the receiving hospital or died following discharge from that hospital. Apparently these patients were counted in the statistics at more than one hospital, which makes one question the validity of the statistics.
7. Many of these patients were treated on multiple occasions at our hospital, which is evident in that we had 1,535 total Medicare admissions for 1986. The statistics only denote 942 cases which is not taking into consideration all of the Medicare patients. Out of 1,535 Medicare admissions, 1,413 patients were discharged alive.
8. In reference to the statistical validity of the numbers, there are 16 diagnostic categories from cancer to severe trauma. The range of cases in each of these categories varied from 1 case to 134 cases with an average of 39 cases for each of the 16 categories. It is impossible to draw any conclusion based upon one case performed in a year and very misleading to draw conclusions on a year long statistical sample of approximately 39 cases.

Dr. William Roper
October 27, 1987
Page 3

In conclusion, we feel it is important that the public is educated and informed about healthcare. However, we also feel that the public has the right to know the background or all of the ramifications of the information. To supply the general public with incomplete information will not achieve the intent of this endeavor. Saline Memorial Hospital hopes that the information provided will give you a more clear understanding of the facts presented.

Sincerely,


Stansel Harvey
Associate Administrator

SH/kd

Memorial Hospital

205 East Jefferson
Siloam Spring, Arkansas 72761
(501) 524-4141



Larry N. Winder
Administrator

October 20, 1987

Health Care Financing Administration
William L. Roper, M.D., Administrator
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 2284
Baltimore, Maryland 21207

Dear Dr. Roper:

A review of the information provided by HCFA revealed one discrepancy in your data. Patient [REDACTED] expired on the date of discharge 09-21-86, not on 09-22-86 as stated in your mortality list. This represents an inpatient death rather than a death within 30 days of discharge.

I would like to take this opportunity to address your statement concerning the use of mortality information itself as an indicator of the quality of care provided by a hospital. It can be stated with some degree of certainty that the term "quality care" in hospitals refers to an appropriate medical management process. The outcome is but one element which reflects quality, and it is often one of the least significant indicators. At Memorial Hospital, each inpatient death is reviewed by the Quality Assurance Committee. The focus of the review is to assure that the attending physician provides a high quality of care to the terminal patient. The physician's critical management of the patient's condition is examined for areas which improvements may be made. To focus exclusively on the outcome of care significantly restricts the ability to judge the quality of care provided by a hospital.

Siloam Springs is a small town in northwest Arkansas. The area has a large percentage of older people which the hospital serves. The reality of the situation is that often society uses hospitals for the care of the terminal patient. People for the most part are uncomfortable in caring for terminal members of their families at home. This is certainly true for Siloam Springs. The physicians and employees of Memorial Hospital realize their role in the care of the terminal patient and strive to provide these individuals with an extra measure of care and concern.

HCA Management
Company
Affiliated with

William L. Roper, M.D.

Page 2

October 20, 1987

Thank you for the opportunity to share the hospital concerns for using mortality information as an indicator of quality.

Sincerely,

A handwritten signature in cursive script, appearing to read "Larry Winder".

Larry Winder, Administrator

LW:kt



October 20, 1987

Giving Quality to Life

William D. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

Dear Dr. Roper:

In September, Sparks Regional Medical Center received mortality information from HCFA pertaining to all Medicare patients admitted during calendar year 1986. While Sparks' actual mortality rates all fell within the range of predicted mortality rates listed in HCFA's 16 diagnostic categories, we appreciate the opportunity to respond to this data in a public forum.

The data used by HCFA for Sparks in developing mortality statistics indicates that a total of 4,050 Medicare beneficiaries were considered for analysis. Of these, 347 died during hospitalization. Our own records indicate that 6,558 Medicare discharges occurred in 1986. Presumably the difference in these numbers reflects multiple admissions of individual beneficiaries. This is primarily due to the chronicity and severity of illness among the elderly in our service area.

The data HCFA used for Sparks indicates that 75 patients died after discharge. Without the detailed data available to your organization regarding deaths following discharge from Sparks, we cannot verify the accuracy of diagnostic data used. Presumably these cases were grouped using the diagnosis code(s) supplied at the time of hospitalization. If so, the actual cause of that patient's death may or may not be related to that diagnosis. For example, a patient admitted and discharged from Sparks with a diagnosis of cerebrovascular accident may have died of severe acute heart disease following discharge and been included in our mortality statistics as a death due to cerebrovascular accident.

Medical record review indicates that specific discharge planning and alternative health settings were used in insuring continuity of care for the above 75 patients. All of these individuals suffered from chronic and severe health problems, and 78% of the patients who died within thirty days were in other hospitals, or in nursing homes, hospice, and home health programs at the time of death.

Sparks is a 681-bed, referral hospital which serves over 30 counties in western Arkansas and eastern Oklahoma. Over 300,000 persons are included in Sparks service area. Sparks routinely provides both acute and specialized care to patients within this service area. Such services include:

- 1) A 32-bed Oncology Unit with medical care provided by four board certified oncologists/hematologists and two board certified radiation oncologists. This unit is one of five accredited in the state of Arkansas by the American College of Surgeons. During 1986, 1,221 patients were treated in this unit.

Sparks Regional Medical Center

1311 South I Street • P.O. Box 2402 • Fort Smith, Arkansas 72902-2402 • (501) 441-4000
Charles Shattfield, FACM - President

- 2) The Stanley E. Evans Heart Institute provides comprehensive cardiac care with medical care provided by 26 board certified cardiologists, internists, and thoracic surgeons. Sparks is the only hospital in the Fort Smith area performing open heart surgery; 300 open heart cases were performed here in 1986.
- 3) An inpatient Medicare certified renal dialysis unit treating chronic renal disease patients during acute phases of their illness. Two board certified nephrologists provide medical care. Treatments totaled 1,387 in 1986.
- 4) A fully equipped JCAH accredited Level II Emergency Room with 5 full-time board certified emergency room physicians, who see 30,000 patients annually.
- 5) A Medicare certified Home Health program which made 5,218 visits in 1986.
- 6) Sparks treated over 18,000 inpatients in 1986 making it the largest acute care provider in the western Arkansas area.

A review of our medical records indicate four errors were made in data reported by HCFA. These are:

<u>Medicare Number</u>	<u>HCFA Data</u>	<u>Corrected Data</u> (Sparks Medical Records)
[REDACTED]	Admission date: 5/22/86 Discharge date: 5/25/86 Date of death: 5/27/86	Date of death: 5/25/86
[REDACTED]	Admission date: 12/26/86 Discharge date: 12/30/86 Date of death: 1/19/87	<u>Additional hospitalization:</u> Admission date: 1/18/87 Discharge date: 1/19/87 Date of death: 1/19/87
[REDACTED]	Admission date: 12/14/86 Discharge date: 12/22/86 Date of death: 12/31/86	<u>Additional hospitalization:</u> Admission date: 12/26/86 Discharge date: 12/30/86 Date of death: 12/30/86
[REDACTED]	Admission date: 2/14/86 Discharge date: 2/28/86 Date of death: 2/28/86	Discharge date: 3/1/86 Date of death: 3/1/86

Thank you again for the opportunity to comment on our 1986 mortality data. Should you have any questions regarding our comments, do not hesitate to call or write.

Yours truly,

Charles R. Shuffield
Charles R. Shuffield
President

Medicare Provider Number 040055



SPRINGDALE MEMORIAL HOSPITAL

P.O. BOX 47 • 607 MAPLE STREET

SPRINGDALE, ARKANSAS 72765

HUGH D. MEANS
ADMINISTRATOR

October 26, 1987

TO WHOM IT MAY CONCERN:

We, at Springdale Memorial Hospital, are firmly committed to our mission of providing the resources necessary to assure that those patients we serve receive the highest quality of care available.

While retrospective review of mortality is an ongoing process within the committee structure of the Medical Staff of this institution, there are many other factors which are constantly reviewed, on a concurrent basis, to assure that treatment of patients, and the results achieved, are appropriate to the illness being treated. Each patient admitted to this institution is reviewed upon admission and a care plan, appropriate to the conditions and severity of illness of the patient, is created. This plan is constantly monitored and adjusted to take in to account the responses of each patient to the treatment being rendered.

Except with respect to a few characteristics included in the statistical model, such as principal diagnosis, the presence of certain selected complicating illnesses, the patient's age and sex, the number of times that the patient was admitted to a hospital during the preceding twelve months, and whether the patient was transferred from another hospital, the data assumes that each hospital's patients are "average". The model does not include other very important measures of severity of illness which must be considered in order to appropriately project expected outcomes of each case. As a result, those hospitals treating larger numbers of more severely ill patients, or who have programs in place for the specialized treatment of the terminally ill patients, could possibly have higher than expected mortality rates. It should be further noted that the mortality rates described in this document apply to only Medicare patients and differ substantially from other indicators of inpatient mortality,

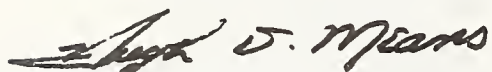
because they are calculated using only those deaths which occurred within 30 days of the last admission of a Medicare beneficiary to our hospital during 1986.

While we at Springdale Memorial are pleased that we fall within the predicted mortality rates of each of the categories listed, we are concerned that this data be carefully interpreted and feel strongly this data should not be used as the single indicator of the quality of care being rendered in any institution.

While this document does not allow space for a complete description of the Quality Assurance Programs currently in place in our institution, we will be pleased to define these programs, and the standards of accreditation to which we voluntarily subscribe , to any interested party.

We are proud of our Thirty-Five years of service to our community and look to the future with confidence in the ability of our Medical Staff to exercise their skills and judgement in directing the care of patients admitted to this hospital.

Sincerely,



Hugh D. Means
Chief Executive Officer
Springdale Memorial Hospital
Medicare Provider #040022



St. Edward Mercy Medical Center

7301 Rogers Avenue • Post Office Box 2405 • Fort Smith, Arkansas 72902-2405 • (501) 484-6000
Administration (501) 484-6100

ST. EDWARD MERCY MEDICAL CENTER

COMMENTS ON THE HCFA MORTALITY DATA

St. Edward Mercy Medical Center (SEMMC) is within the HCFA "predicted" mortality ranges in all categories, and in total. However, the statistical methods used by HCFA to determine their "predicted" ranges do not consider a sufficient number of hospital-specific characteristics to provide the public with an accurate predictor of reasonable quality at the individual hospital level. At the national level, these methods are "statistically significant" and can be used to arrive at sound conclusions. At the institutional level, they provide unsound estimates at best, depending on the "uniqueness" of a hospital with regard to characteristics not considered by HCFA. We have provided some examples of such characteristics of SEMMC below which the HCFA methods are not sensitive to. We monitor mortality data internally on an ongoing basis in our Quality Assurance Program, so we have gained no operational benefit from the release of this information.

The data used by HCFA indicate that from a total of 3100 Medicare beneficiaries who received care at St. Edward Mercy Medical Center in 1986, 364 of those individuals died within 30 days of admission. Of these, 312 died while still an inpatient at St. Edward, while 52 died after discharge, but still within 30 days of admission. Our own records indicate that 5105 Medicare admissions occurred in 1986. Presumably the discrepancy reflects multiple admissions of individual beneficiaries to St. Edward.

St. Edward Mercy Medical is a well established referral facility for regional rural hospitals and physicians in northwest Arkansas and eastern Oklahoma. A study of our records indicate that of the 364 terminal cases, we received: 24 as transfers from other hospitals in our region, 52 as transfers from regional nursing homes, and 288 from home. 69% of these patients came to us by way of our Emergency Services Department. A significant number of the patients we admit from "home", are also of the "regional referral center" type because they are rural physician-to-SEMMC staff physician referrals. By the nature of the HCFA methods, recipient referral centers which care for acutely ill individuals will have deaths attributed to them as the final hospital in the channel of care.

In the absence of a comprehensive measure of severity of illness, the HCFA method of analysis is misleading when applied at the institutional level. For example, our records indicate that of the 364 terminal cases, 157 (43%) were cases in which "do not resuscitate" orders were in effect at the patient's or family's request.

Managing:

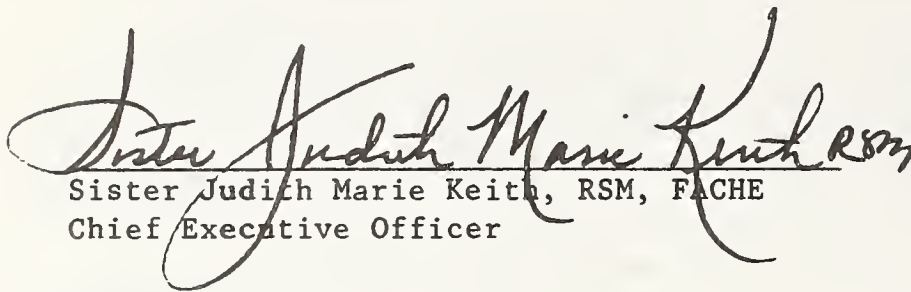
North Logan Memorial Hospital, Paris, Arkansas
Mercy Hospital of Scott County, Waldron, Arkansas

Pinewood Nursing Home, Waldron, Arkansas
Harbor View Mercy Hospital, Fort Smith, Arkansas

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

It would be most difficult and intrusive to verify the status of the individuals shown by HCFA to have died after discharge, as information concerning death after discharge is not included in the patient's medical record. Of the 52 individuals who died elsewhere, but within 30 days of admission to SEMMC: 2 were transferred to other acute care hospitals, 15 were discharged in stable or stabilized but known terminal condition to nursing homes, and 35 were discharged home in stable or stabilized but known terminal condition.

Finally, the HCFA data for SEMMC does not include psychiatric cases because we operate a freestanding mental health center under a separate Medicare provider number, which cared for 195 Medicare beneficiaries in 1986. Had they been admitted to an inpatient unit in the manner that most full service hospitals provide this service, the SEMMC overall mortality rate would have been "diluted" by this low fatality category of illness to 11% rather than 12% as shown by HCFA.


Sister Judith Marie Keith, RSM, FACHE
Chief Executive Officer

SJM/mo

October, 1987



St. Joseph's Regional Health Center

100 Whittington Avenue
Hot Springs, Arkansas 71901
Phone (501) 624-5451

October 30, 1987

William L. Roper, M.D., Administrator
Department of Health and Human Services
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Dear Dr. Roper:

We have reviewed the mortality data developed by HCFA on St. Joseph's Regional Health Center's 1986 Medicare discharges. There appears to be no significant error in calculation.

However, St. Joseph's does not believe that the public interest is served by the publication of hospital specific mortality data. It should be noted that St. Joseph's data fell within the predicted range for each diagnostic category.

Our concerns are two-fold: 1) that the HCFA model does not measure hospital specific quality; and 2) that the public confidence in the health care delivery system may be adversely affected by the publication of hospital specific index.

Hospital Mortality is an indicator of a number of performance variables and not a measure of quality for any subset of the variables. Age, sex, certain co-morbidities are considered within the HCFA model. At the same time, significant other factors are not considered: accidents, chance, etc. At best, mortality data may direct specific study of a diagnostic category in order to identify performance. Quality is as yet not well defined by any of the health care evaluators (regulators), HCFA, JCAH, state health agencies, AHA, etc.

A Member of the Sisters of Mercy Health System - St. Louis

October 30, 1987
William L. Roper, M.D.
Page 2

Consumers (Medicare beneficiaries) cannot appropriately utilize the HCFA published data to make inferences about hospital quality. HCFA and every recognized health care delivery association, regulator, payor, agree upon this point. Nor do any of these groups agree precisely on the usefulness of the data. It can hardly be expected that the publication of this data will benefit the public. In fact, the potential for misuse far outweighs any benefit.

In light of the above, and in recognition that responsible groups (AHA and JCAH) are working to develop real quality definitions and measurements, we request that HCFA not publish raw mortality data.

Sincerely,


David B. Wingfield
Chief Operating Officer

DBW/gk

Comments from St. Mary-Rogers Memorial Hospital, Medicare # 040010:

Of the 1,373 Medicare patients admitted to St. Mary-Rogers Memorial Hospital in 1986, 165 patients died within 30 days of admission. The average age of these patients was 77 years.

Our mortality rates all fall within the predicted ranges with the exception of the category for cerebrovascular accidents. Seventeen of the 38 patients (or 45%) are listed by the Health Care Financing Administration as having died within 30 days of admission to our hospital; one of these patients was admitted, not in 1986 but in 1985, and died in 1986. If that patient's admission were deleted from the list, the actual mortality rate for that category would be 43% and within the predicted range of mortality rates.



OPERATED BY DOMINICAN SISTERS



October 22, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Gentlemen:

Following are our comments regarding mortality information provided by the Health Care Financing Administration for Medicare patients treated in 1986 in St. Vincent Infirmary, Little Rock, Arkansas. (Medicare Provider Number: 040007)

Our comments fall into three categories. Section A contains our observations about the accuracy of the data. Section B contains comments regarding interpretation, use and limitations of the data. Section C outlines a few factors that may influence the results reported for St. Vincent Infirmary.

SECTION A - ACCURACY OF DATA

1. HCFA data indicate we treated 5,543 Medicare patients, 580 of whom died within 30 days of admission. Of these, 491 died in the hospital, 89 died after discharge.
2. Our records indicate 9,274 Medicare admissions involving 6,700 patients, 494 of whom died in the hospital.
3. The discrepancy between our 6,700 figure and the 5,543 reported by HCFA is likely accounted for primarily by patients who had multiple admissions and whose final admission was somewhere other than St. Vincent, and who, therefore appear on the HCFA reports for other hospitals. (Only patients whose last admission during 1986 occurred at St. Vincent are included in the 5,543.) There also will be some in the 6,700 who died, but whose death occurred from 31 to 335 days after admission. They do not therefore meet the HCFA criteria and are not included in the 5,543.
4. Our records regarding the 580 Medicare patients who died shows that 494 (rather than 491) expired in the hospital. If the 580 figure is correct, this would leave 86 (rather than 89) who died after discharge. We have no way of verifying that figure.

5. There are a few other very minor discrepancies. One Medicare number appeared twice. One patient's name on the list could not be matched, but we did have a patient under another name with the same age, sex, and Medicare number who expired on the listed date. Dates of death, ages and sex of all patients matched the HCFA data.
6. According to HCFA, on a national basis about 80% of all Medicare deaths should be expected to result from the 16 specific disease categories reported. In our case the percentage is 78.8% (457 of 580 deaths, the other 123 resulting from causes not individually identified in the HCFA information release, but included in the total count).

SECTION B - INTERPRETATION, USE AND LIMITATIONS OF DATA

1. We are pleased the HCFA data shows St. Vincent on the low side of the predicted mortality range both in the aggregate and in each of the 16 disease categories. Hopefully this allows us to comment on the interpretation and limitations of the data without appearing to be defensive or having an axe to grind.

The key point in interpretation is that while mortality figures can be of great value in focusing peer review activities, the HCFA figures, for reasons outlined below, must not be used to infer high or low quality, or to compare quality among institutions. Just as a good outcome can result even where care was only marginal, so a poor outcome can result even where care was exceptionally good. Mortality rates higher or lower than the "predicted mortality" range can reflect quality differences, of course, but can also result from a variety of other reasons, including chance and factors not taken into account in the HCFA study.

2. For example, the HCFA model assumes that each hospital's patients are "average" except with respect to several characteristics...the principal diagnosis, the presence or absence of a few selected complications, age, sex, and number of times admitted during the past year. Not considered in the model are such significant variables as the patient's general health at time of admission, the severity of the illness, whether the patient had a terminal illness and was expected to die, whether the patient was receiving care at home prior to admission, whether the patient was transferred from a nursing home and the extent of family support available to the patient both before hospitalization and more importantly, after discharge.
3. Also, by covering a 30-day period from the date of admission, the study does not identify deaths that result after discharge from conditions unrelated to the condition under which the death is categorized in the HCFA report. A case in point: our own data show two deaths under the "ophthalmologic disease" category. Our records for those two patients show that one was suffering from cancer and was admitted for an eye procedure to help improve his vision. He expired from the cancer shortly after discharge from the Infirmary. The second death occurred in a patient over 90 years of age who just happened to be being treated at the time for an eye condition. His was not an "ophthalmologic disease"-related death.

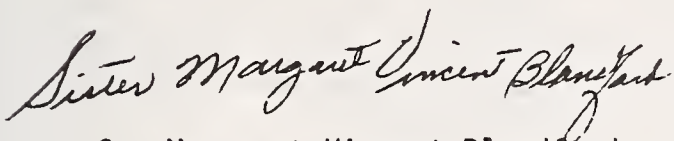
4. Finally, the HCFA model considers only the last admission. Thus the model fails to give due "credit" for perhaps as many as several instances in which a patient may have received exceptional care, extending his life, but the one admission resulting in death is counted.
5. If the HCFA mortality data are potentially misleading as indicators of quality, is the material of any value? We believe it clearly is of great potential value in providing a focus for ongoing and new peer review activities. Quality is of enormous importance. Our Board of Directors has approved major facility and equipment expenditures designed to maintain a state-of-the-art facility. Educational programs prepare employees at all levels for their responsibilities. Our physicians devote thousands of hours each year to ongoing peer review activities, quality assurance activities and credentialing processes, not to mention programs of continuing professional education in all specialties. The mortality data provided by HCFA and the refinements that can be expected in the coming years as the process matures will be an invaluable source of data upon which to build more effective programs not only to monitor quality, but to improve it.

SECTION C - OTHER SIGNIFICANT VARIABLES

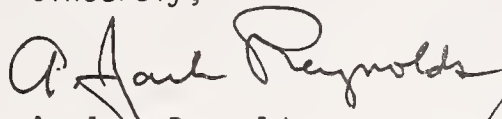
1. As with most programs national in scope, the HCFA information does not adequately address local variables. Some of the following affect many Arkansas hospitals. All affect St. Vincent Infirmary and its mortality expectations.
 - a) As a state with a relatively high percentage of poor citizens, it is logical to expect that medical treatment is often delayed longer than might be expected in more affluent economies with higher percentages of better insured employees. This would affect the severity of illness at time of entry into the health system...one of those variables not considered in the HCFA model.
 - b) Our state also has a high percentage of elderly citizens. In parts of the state nursing home facilities are limited. Couple these conditions with the economic situation mentioned above. The result is that significant numbers of patients with chronic degenerative diseases may be admitted to hospitals shortly before death, raising mortality expectations.
 - c) St. Vincent treats a high number of elderly patients and receives a high number of patients from nursing homes. We treat more cancer patients than any other Arkansas hospital. And we are a major referral center with a high percentage of high-risk patients from outlying areas. Given all these factors, we might have expected higher mortality rates than those reported by HCFA and are looking forward to using the HCFA data to strengthen our quality assurance activities even further.

We appreciate the opportunity of adding our comments to the data you intend to publish.

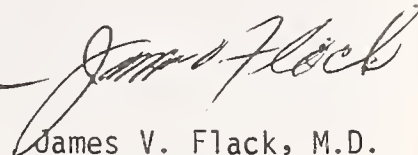
Sincerely,



Sr. Margaret Vincent Blandford
Chief Executive Officer



A. Jack Reynolds
President



James V. Flack, M.D.
Chief of Staff

sc

COMMENTS ON THE 1986 HCFA MORTALITY DATA
Baptist Medical System
Little Rock, Arkansas

The Baptist Medical System includes three acute care hospitals, Baptist Medical Center is a 739-bed tertiary care hospital located in Little Rock; Memorial Hospital is a 260-bed community hospital in North Little Rock; Twin Rivers Medical Center is a 57-bed community hospital in Arkadelphia.

Baptist Medical System hospitals strive to be "centers of excellence." Providing quality care to our patients is of utmost concern to the governing board, medical staffs and management. We recognize the value of mortality data in the identification of potential quality problems. Periodically (monthly, quarterly, etc.), we evaluate data for trends or potential problems. If a case is questionable, we don't hesitate to take action to correct the problem and prevent further occurrences.

Although the reported data indicates that we are within (or below) the predicted range in all categories, we strongly disagree with the implication that this data can be used as a measure of quality.

Our concerns are based on the following:

1. We cannot verify the accuracy of HCFA statistics on deaths after discharge because we do not have access to the Social Security data used.
2. We received an inadequate description of the methodology used to calculate expected mortality rates. We cannot duplicate it for our own use.
3. THE MODEL HAS NOT BEEN VALIDATED. The reliability of the mode is unknown, but appears limited.
4. The patient's severity of illness is not taken into account. A hospital's mortality rate may be significantly impacted by difference in case mix.
5. A higher than average mortality rate does not necessarily mean poorer performance. A hospital may specialize in high risk cardiac and trauma surgery, or have large number of chronic lung disease patients requiring long term ventilator use, or a hospice service.

6. Attributing a patient's death to an individual hospital based solely on the fact that the patient died within 30 days of admission does not measure the quality of care provided in that facility or by the attending physician. The statistics do not take into consideration noncoded contributing diseases or complications due to lack of space on the bill. Other factors which must be considered are:
 - A. The use of medical services early in the course of the disease causing a timely diagnosis and admission for treatment.
 - B. The appropriateness of outpatient services provided.
 - C. The availability and quality of post hospital services and treatment.
 - D. The general health status of the patient, stage of illness and psychological condition.
 - E. Social factors, such as family support and dynamics.
7. There are discrepancies between the hospital's abstracted data, the local peer review organization's data and the HCFA data provided. For example, the data by HCFA indicate that a total of 5594 Medicare patients were last admitted in 1986 to Baptist Medical Center. We have no way to readily verify the number of cases, since our data is based on all Medicare admissions during 1986, which was 9117. Of those 5594 cases, 436 deaths within 30 days of admission were reported. We were able to verify only 431 of those deaths. HCFA also reported that 63 of the deaths occurred after discharge. Our records indicate that 3 of the reported deaths after discharge actually occurred in Baptist Medical Center, decreasing the number to 60.
8. The summary of mortality data does not include critical information such as age (90% of patients may be over 80 years old).

While we recognize the need to provide the consumer with valid and useful information on the quality of hospital care, we believe that better measures are needed. We are currently working with the American Hospital Association and other organizations, including the Joint Commission on Accreditation of Hospitals, to develop methods of evaluating hospital quality nationwide that rely on measures other than mortality rates.

HOSPITAL ID NUMBERS

BAPTIST MEDICAL CENTER = 040114
MEMORIAL HOSPITAL = 040036
TWIN RIVERS MEDICAL CENTER = 040066



October 27, 1987

William C. Roper, M.D.
Administrator
Health Care Financing Administration
6325 Security Boulevard
Baltimore, Maryland

Dear Dr. Roper:

The data used by HCFA indicates that a total of 152 Medicare patients admitted to The University Hospital of Arkansas died within 30 days of admission. Of these, 108 died while still a patient of the hospital, while 44 died after discharge. The HCFA data also indicates a total of 1,386 cases while our own records indicate that 2,659 Medicare admissions occurred in 1986. Presumably, the discrepancy reflects multiple admissions of individual beneficiaries to different hospitals. Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

We recognize that in all seventeen categories, the hospital's actual mortality rate falls within the range of the predicted mortality rate. However, our feelings are that mortality rates by themselves are not a measure of quality. Mortality data are appropriate to guide or help focus peer review. Comparisons of actual and predicted mortality rates can only suggest that the hospital and its medical staff review an area to determine if a quality problem does exist or if the patients treated by the hospital are simply unusually complex or have other characteristics not recognized by the HCFA model.

The University Hospital of Arkansas is a major referral center receiving high risk patients in several patient categories. These include severe acute heart disease, renal failure, trauma, burns, and catastrophic infectious diseases. The model does not seem to address this type of patient mix or utilize any measures of severity.

Thank you for the opportunity to contribute to your final publication, and we look forward to working with you in the future.

Sincerely,



Richard A. Pierson
Executive Director

RAP/jb



Warner Brown Hospital

October 23, 1987

460 WEST OAK STREET
POST OFFICE BOX 1998
EL DORADO, ARKANSAS 71731-1998
TELEPHONE 501/863-2000

COMMENTS OF THE HCFA MORTALITY DATA Warner Brown Hospital, El Dorado, Arkansas 04-0088

The data used by HCFA indicates that a total of 169 Medicare patients admitted to Warner Brown Hospital expired within thirty (30) days of admission. The average age of these patients is 77. Of the 169, 144 expired while still a patient in the hospital while 25 expired after discharge. Our own records indicate that 2118 Medicare admissions occurred in 1986 but your statistics indicated that you only reviewed 1235. It is impossible to determine the percentage of the 25 patients expiring after discharge who were still alive as of the report date, as information concerning death after discharge is not included in the patient's record.

Warner Brown Hospital has a very active Medical Staff Quality Assurance Committee and Utilization Review Committee whose purpose is to identify, develop plans of action and do follow-up review. We feel that these committees do an excellent job in monitoring our quality of care. This is indicated in your analysis since Warner Brown Hospital did not exceed your predicted range of mortality in any category. However, we will feel that the HCFA presentation of this data is of questionable value. In addition, the validity and reliability is in itself, as presented, questionable as stated on pages 3 and 4 of the September 21, 1987, information packet. These statistics are simply raw statistics without indication of differences of individual hospitals in regard to geographical locations and purpose/scope of the hospital which could radically alter some of the raw statistics.

Oncology and end-stage renal disease programs could contribute significantly to the prognosis of the patients.

In summary, we do not feel the publication of this data is beneficial to anyone and is, in fact, confusing and misleading to those who might use it.



**Washington
Regional**
Medical Center

October 23, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Sirs:

This letter is in response to your September 21, 1987 letter in reference to the publishing of selected mortality information about all short term acute care hospitals which treated Medicare patients in 1986.

Attached is Enclosure I which are comments by Washington Regional Medical Center in reference to the subject of the letter. As you requested, this information is no more than two pages and is on the Washington Regional Medical Center letterhead and our Medicare Provider number is also included.

Enclosure II is the list of patients by hospital ID# provided by HCFA. This has been thoroughly reviewed and corrections are noted by number in the lefthand column with a supporting history at the bottom of each page.

In conjunction with our quality assurance staff, Donald B. Baker, Physician Director of Quality Assurance for Washington Regional Medical Center, who is also a PRO reviewer with eminent qualifications, prepared the comments in Enclosure II. Dr. Baker is available for questions in reference to any aspects of the presented remarks.

Sincerely,


Earl W. Eddins
Administrator

ef

Enclosures

1125 North College Avenue • Fayetteville, Arkansas 72703 • (501) 442-1000

A COMMITMENT TO QUALITY

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

WASHINGTON REGIONAL MEDICAL CENTER
1125 North College Avenue
Fayetteville, Arkansas 72703
(501) 442-1000

HCFA's RELEASE OF MORTALITY RATES

WRMC is not opposed to release of information pertaining to its performance as a deliverer of health care. This institution is extremely proud of its outcome and services it provides to the community. It is the opinion, though, of WRMC that the proposed mortality rates is not meaningful information that can be used by the consumer for an informed decision and is not helpful to the institution for insight to patient care.

HCFA postulates that given the age, sex, principal diagnosis (condition that caused admission), and principal procedure (operation), in a patient that dies during or within 30 days of discharge, a mortality rate can be determined that can be used to reflect quality of care and be used to compare various institutions. This data is further placed in specific headings such as to cancer, heart disease, determined by the principal diagnosis and principal procedure but not the cause of death. This information is most difficult to interpret and, after review, does not reflect the true clinical picture and certainly does not reflect management or quality. Analysis of the data reveals it to be a mathematical projection or model that does not express clinical information. The overall range of projected mortality is specific to WRMC and cannot be compared to the predicted rates of other hospitals. The predicted rate for each specific diagnostic category also does not relate to the cause of death or management, but simply says, that a patient admitted under the heading of gastroenteritis has a predicted death rate of 2-9% within 30 days of their last hospitalization, regardless of the cause of death. This is statistically correct, but is not medically meaningful or appropriate. It does not give a consumer information as to the management or of the quality of care given to WRMC. For example, a patient admitted with nausea and vomiting as an effect of radiation therapy is placed, by HCFA, in the heading of gastroenteritis, even though the patient dies within 30 days of admission from cancer. One must assume then that the cause of death was associated with gastroenteritis or its management, which is not correct. Also there is no mechanism to show staging or severity of disease. For example, the mortality rate cannot be compared of a 65 year old life long insulin dependent diabetic with multiple complications and an 80 year old diabetic with recent onset of the disease in generally good health. Death in one may be accepted, while death in the other could reflect poor management. Further review of specific headings can be confusing. Severe trauma heading would imply that death was the direct cause or result of trauma. Specific chart review at WRMC revealed hip fracture to be the severe trauma used in this study and that only one patient died as a result of the hip fracture. The other deaths were not related to the hip fracture or its management.

The only true fact that can be derived from this information is that the mortality rate for a patient on Medicare during 1986 was 12% at WRMC, compared with a predicted rate of 8-15%. This is regardless of age, sex, reason for admission and principal procedure.

HCFA has suggested that this information offers a hospital further insight into the result of patient care not previously available. This is most erroneous in

ENCLOSURE I

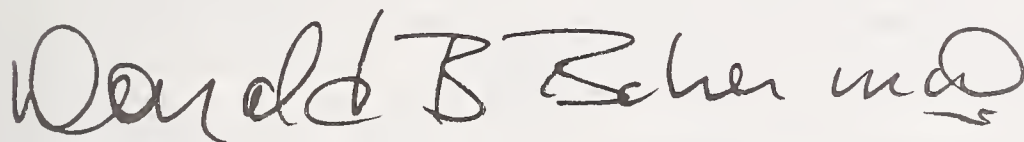
WASHINGTON REGIONAL MEDICAL CENTER
1125 North College Avenue
Fayetteville, Arkansas 72703
(501) 442-1000

HCFA's, continued from page 1.....

that hospitals and physicians, for years, have been doing in-depth review of patient care and, particularly all deaths. This is evidenced by multiple committees, including surgical and medicine control committees, quality assurance committees, utilization review, specific monitors of patient care set up through quality assurance, tissue review, blood utilization, pharmacy and anesthesia committees, as well as all death charts being reviewed. In this instance, specific management is reviewed as it relates to the overall and specific disease and not to the reason for admission or principal procedure. This is appropriate and this information can be measured against professionally recognized standards of care.

In 1983 congress legislated that HCFA, through the PRO, review medical care in hospitals and by individual physicians. This review was to address care that was medically necessary, that met professionally accepted standards, and was provided economically and adequately documented. The PRO's also have been charged to review quality of care that the patient received while in the hospital and for care after leaving the hospital. The review has resulted in major changes in health care and has identified many hospitals and physicians with adverse patterns of care that have even resulted in exclusion from the Medicare program. This information gathered by the PRO is much more specific as to the quality and the appropriateness of care and would be much more meaningful and useful as to comparison of care provided by hospitals and physicians. The HCFA mortality release distorts the effort of the PRO in relation to this hospital and quality of care offered as well as all hospitals through out the United States.

WRMC falls into all accepted ranges of percentages of mortality in comparison to the predicted. We do not believe that this mortality criteria relates to the excellence of care being provided in this institution. The appropriateness and excellence of an institution, or the failure of a hospital to meet its obligations in the delivery of health care cannot be portrayed by the release of this information. The information must be appropriate and relevant to allow a decision or proper conclusion to be made, particularly to the consumer.



Donald Baker, M.D.

BOARD OF GOVERNORS
CHARLES E. YINGLING, CHAIRMAN WAYNE HARTSFIELD
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ADMINISTRATOR

WHITE COUNTY MEMORIAL HOSPITAL

P. O. BOX 809

PHONE 501/268-6121

SEARCY, ARKANSAS 72143

HS

September 30, 1987

Department of Health and Human Services
William L. Roper, M.D.
The Administrator
Washington, D.C. 20201

Dear Dr. Roper:

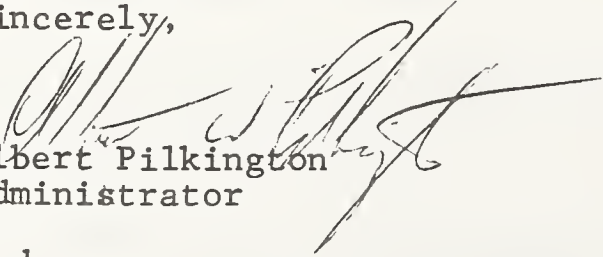
This is in response to your mortality statistics to be released in December, 1987.

I strongly feel that the release of this type of mortality data will cause the general public, our future patients, to use this as the sole indicator of our hospital's patient quality care. I feel this mortality data will be used by people to decide which hospital that they should use because of lower death rate. It should be noted in very plain terms that this statistical mortality data was gathered on basically terminally ill patients or patients with a diagnosis of an incurable disease.

We probably treat more than an average number of Medicare patients in our hospital; therefore, this gives us a higher mortality rate and as the general public looks at this mortality data, it will be very misleading and will hurt not only our hospital, but other hospitals that treat a large percentage of Medicare patients. If mortality statistics must be given, in my opinion, it should be of an overall census, not just the high risk, terminally ill Medicare patients.

Our hospital gives high quality care and I feel this mortality data is damaging to us.

Sincerely,


Albert Pilkington
Administrator

tcd

COMMENTS ON THE HCFA MORTALITY DATA

WHITE RIVER MEDICAL CENTER

BATESVILLE, ARKANSAS

Of 1,335 cases, HCFA's data identified 158 Medicare patients whose last admission in 1986 was to WRMC and subsequently expired within 30 days of admission. This represents an actual mortality rate of 12%, well within the predicted mortality rate for a similar group of patients with specific characteristics identified by HCFA's statistical model. Sixteen (16) diagnostic categories of relative high and low risk for death accounted for 120 of these patients. The actual mortality rate for each of the 16 categories was within the range predicted by HCFA. Twenty-five (25) of the 158 deaths occurred after discharge from the hospital and 133 deaths were inpatients.

Two categories, severe chronic heart disease and severe acute heart disease accounted for 21 and 23 deaths, respectively. The actual mortality rate for these categories is toward the upper limits of the predicted mortality rates, but within the range.

It is felt that a variety of factors may contribute to a slightly high mortality rate for these two categories. One factor may be that a nursing home shortage exists in our service area. For example, a one-year waiting list for admission to a nursing home in Independence County may have prompted more patients to remain at home until death was imminent. A second factor may be White River Medical Center serves the northcentral area of Arkansas as a referral center. Many services are available here that are not available at other smaller, rural hospitals; i.e. two cardiologists have full-time practices at Batesville; a highly-sophisticated cardiac catheterization lab is available at White River Medical Center. These are just a few factors that may have contributed to a slightly high mortality rate for the heart disease categories.

The statistical model HCFA used is an initial, but crude, step in an increasing effort to evaluate the quality of patient care services. Mortality data alone, as is this model, does not directly measure quality of care. Instead, a complex set of variables intertwine to determine patient's outcomes. These variables may include how ill the patient was at admission, whether the patient was transferred from a nursing home on admission, whether the patient was receiving treatment at home, whether a terminal illness was present, and the patient's psychological or general health status. Therefore, HCFA has simply provided data that can only serve as a guide or indicator of quality that must be further evaluated.

At White River Medical Center, high value is placed on evaluating the quality of health care services we provide to our patients. In fact, a hospital-wide quality assurance program has been developed that extends to all hospital departments and each medical staff member, as well as other staff. Routine, continuous monitoring of activities

Comments on the HCFA Mortality Data
White River Medical Center
October 27, 1987
Page 2 of 2

occurs, and any indication of potential quality problems leads to prompt investigation to determine if a problem, in fact, exists. When quality problems are identified, corrective action is swiftly taken. Quality of care is of the utmost concern to the hospital's Board of Trustees, Medical Staff, and employees.

California

Medicare Hospital Mortality Information

HOSPITALS		High Risk Diagnostic Categories																							
		Overall			Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
Name/Location	Comment/Reference																								
AGNEWS STATE HDSP SAN JOSE CA 95134	CA-39	1	0	0-100																		1	0	0-100	
ALAMEDA HDSP ALAMEDA CA 94501	CA-40	1288	16	11-18	82	20	13-34	80	35	19-40	31	16	5-33	89	18	15-33	55	38	28-54	23	22	8-44	135	35	15-31
ALEXIAN BROTHERS HDSP SAN JOSE CA 95116	CA-41	1146	14	11-19	55	24	12-37	62	31	20-44	45	18	9-34	100	24	15-32	56	39	27-53	41	22	8-35	142	21	14-29
ALHAMBRA COMM HOSP ALHAMBRA CA 91801	CA-42 *	944	12	10-18	42	38	14-42	43	19	16-44	26	23	7-39	67	25	17-38	36	56	23-55	33	12	7-36	106	20	16-34
ALTA BATES HOSP BERKELEY CA 94705	CA-43	2286	12	10-16	245	26	17-33	98	28	21-40	55	16	11-34	135	22	16-31	66	44	28-53	60	22	10-34	173	14	13-27
ALTA HOSP DISTRICT DINUBA CA 93618	CA-44 *	411	13	10-19	11	45	13-66	14	43	12-57	10	10	4-53	27	19	10-42	20	60	22-63	10	20	2-51	63	21	12-34
ALVARADO COMM HOSP SAN DIEGO CA 92120	CA-45	2377	12	9-15	145	37	17-35	59	19	18-41	40	25	11-39	145	17	16-31	78	37	26-49	80	28	11-32	220	23	14-28
AMADOR HOSP JACKSON CA 95642	CA-46 *	490	11	9-17	29	38	9-41	22	23	14-51	18	0	6-44	38	13	10-37	25	32	22-59	16	13	7-48	45	11	8-31
AMERICAN RIVER HOSPITAL CARMICHAEL CA 95608	CA-47	2271	16	9-16	162	30	18-35	77	38	18-39	53	25	11-35	125	30	15-31	74	42	27-51	49	20	7-32	262	29	14-26
AMI CLAIREMONT COMMUNITY H SAN DIEGO CA 92117	CA-48 *	511	9	7-15	34	18	13-44	19	37	11-50	14	7	4-45	28	11	10-41	19	42	19-61	9	0	4-57	36	14	9-35
AMI GLENDORA COMMUNITY HOS GLENDORA CA 91740	CA-49	701	15	10-17	22	59	14-53	27	44	15-49	16	6	5-45	34	21	12-41	14	71	19-67	21	19	8-45	115	18	16-33
AMI MEDICAL CENTER OF HOLL NORTH HOLLYWOOD CA 91607	CA-50	919	18	10-17	33	15	8-37	30	57	15-47	20	15	6-41	57	21	13-35	46	63	28-57	23	9	5-39	117	38	16-34
AMI MISSION BAY MEMORIAL H SAN DIEGO CA 92109	CA-51 *	1002	11	9-16	64	27	13-36	41	27	17-45	15	27	5-45	49	10	12-35	41	46	24-54	20	10	4-39	109	15	13-30
AMI SIERRA VISTA REGIONAL SAN LUIS OBISPO CA 93401	CA-52	1650	12	9-16	197	30	16-32	82	24	19-39	38	5	7-33	75	17	15-35	56	34	26-52	31	10	7-38	105	13	12-29
AMI VALLEY MEDICAL CENTER EL CAJON CA 92021	CA-53	1344	19	11-18	72	24	14-36	60	37	18-41	37	16	8-35	79	23	14-33	51	53	28-56	62	23	8-31	216	34	15-29
AMI/COMMUNITY HOSP OF SANT SANTA CRUZ CA 95062	CA-54	906	11	9-17	60	8	9-31	38	21	17-47	40	13	7-33	56	32	15-37	37	35	23-54	23	26	6-41	94	19	12-30
ANAHEIM GENERAL HOSPITAL ANAHEIM CA 92804	CA-55	506	15	9-17	27	26	11-44	20	20	12-50	8	13	4-59	39	21	14-42	10	80	15-70	18	22	4-41	56	25	12-34
ANAHEIM MEM HOSP ANAHEIM CA 92803	CA-56	1706	12	9-16	110	33	19-39	38	34	17-46	28	18	5-35	109	27	15-31	43	33	24-54	45	24	15-44	123	28	15-32
ANTELOPE VALLEY HDSP MEDIC LANCASTER CA 93534	CA-57	1267	11	8-15	67	22	14-38	42	31	16-43	30	20	5-33	74	19	13-33	42	38	23-53	49	16	9-34	105	21	12-29
ARROYO GRANDE COMM HOSP ARROYO GRANDE CA 93420	CA-58	883	13	9-17	60	32	14-38	38	34	15-44	25	12	5-36	55	33	15-38	43	42	24-54	22	14	7-42	92	16	12-30
AUBURN FAITH COMMUNITY HOS AUBURN CA 95603	CA-59	1296	14	9-16	118	28	14-33	63	32	18-41	49	20	7-31	45	24	13-38	46	30	28-56	32	6	6-36	156	24	14-29
AVALON MUNICIPAL HOSP AVALON CA 90704	CA-60 *	21	5	4-35	1	0	3-99	1	0	1-97	1	0	0-99	1	100	0-97	1	0	2-98	1	0	0-99	4	0	0-79
AVENAL DISTRICT HOSPITAL AVENAL CA 93204	CA-61 *	102	7	8-23	7	29	11-73	2	0	1-89	5	0	1-68	3	33	3-83	8	25	12-71	1	0	0-98	21	0	3-35
BAKERSFIELD COMMUNITY HOSP BAKERSFIELD CA 93308	CA-62	401	13	8-17	27	15	8-40	15	13	12-56	13	15	5-48	21	29	9-44	14	43	18-66	14	29	4-46	57	28	8-30
BALDWIN PARK COMMUNITY HDS BALDWIN PARK CA 91706	CA-63	364	18	9-18	3	33	2-82	13	38	10-56	18	6	5-42	31	26	11-41	18	78	21-65	15	13	4-45	53	30	10-33
BARSTOW COMMUNITY HOSP BARSTOW CA 92311	CA-64 *	484	12	8-16	18	39	12-53	16	31	13-57	7	43	4-63	35	26	10-38	19	21	20-62	19	26	5-43	61	20	9-30

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

CA-2

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
AGNEWS STATE HOSP SAN JOSE CA 95134	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	
ALAMEDA HOSP ALAMEDA CA 94501	17	35	13-59	15	27	13-59	49	6	5-25	3	0	0-100	110	4	3-14	59	12	2-18	14	7	0-46	107	4	2-12	70	1	0-10
ALEXIAN BROTHERS HOSP SAN JOSE CA 95116	13	23	9-60	17	29	15-60	27	7	4-30	3	0	0-100	100	9	3-13	46	9	2-20	5	0	0-99	108	4	2-12	51	2	0-14
ALHAMBRA COMM HOSP ALHAMBRA CA 91801	10	0	4-57	15	13	18-66	48	6	3-20	3	0	0-100	72	4	2-14	28	14	1-25	12	0	0-97	95	3	2-12	63	0	0-11
ALTA BATES HOSP BERKELEY CA 94705	22	23	8-49	30	30	23-60	82	6	5-20	3	0	0-100	200	6	3-11	66	6	1-15	37	0	0-81	151	4	2-10	177	3	1-6
ALTA HDSP DISTRICT DINUBA CA 93618	7	29	5-66	8	25	12-72	9	0	1-50	.	.	.	26	0	1-24	16	6	1-35	1	0	0-100	61	0	1-14	11	0	0-58
ALVARADO COMM HOSP SAN DIEGO CA 92120	19	21	6-49	24	29	20-60	61	11	3-20	24	0	0-48	161	6	3-11	110	5	1-12	11	0	0-80	425	3	3-8	142	1	0-6
AMADOR HOSP JACKSON CA 95642	4	0	5-80	6	50	8-74	13	15	1-40	1	0	0-100	40	10	2-19	23	0	0-39	1	0	0-100	39	8	1-18	37	0	0-19
AMERICAN RIVER HOSPITAL CARMICHAEL CA 95608	18	28	7-50	10	30	11-65	87	7	4-18	6	0	0-100	189	7	2-10	130	7	2-12	14	0	0-94	152	7	2-10	108	3	0-8
AMI CLAIREMONT COMMUNITY H SAN DIEGO CA 92117	4	25	1-76	2	100	5-93	14	14	1-38	1	0	0-100	43	12	1-17	27	0	1-25	5	0	0-99	29	3	1-21	21	0	0-36
AMI GLENDORA COMMUNITY HOS GLENDORA CA 91740	11	9	8-61	7	29	11-73	9	0	2-51	.	.	.	58	9	2-16	19	0	1-31	5	0	0-100	73	8	2-14	43	0	0-18
AMI MEDICAL CENTER OF HOLL NORTH HOLLYWOOD CA 91607	13	62	8-58	11	18	13-66	21	5	3-34	19	0	0-74	44	7	1-16	31	10	3-27	9	0	0-84	68	4	1-13	56	4	0-13
AMI MISSION BAY MEMORIAL H SAN DIEGO CA 92109	8	63	8-69	17	29	16-61	23	13	1-28	7	0	0-100	111	7	2-12	41	5	1-19	2	0	0-100	94	2	2-11	66	3	0-11
AMI SIERRA VISTA REGIONAL SAN LUIS OBISPO CA 93401	6	33	13-81	32	38	21-56	54	4	3-20	6	0	0-100	121	7	3-12	63	3	0-15	31	0	0-38	87	1	2-12	208	1	0-5
AMI VALLEY MEDICAL CENTER EL CAJON CA 92021	15	53	13-62	22	59	18-58	47	9	3-21	18	0	0-86	111	6	2-11	72	10	3-17	11	0	0-99	101	7	2-11	44	2	0-16
AMI/COMMUNITY HOSP OF SANT SANTA CRUZ CA 95062	14	14	10-59	11	18	13-66	53	8	3-20	9	0	0-100	77	5	2-14	26	15	0-26	9	0	0-97	79	0	2-13	54	0	0-15
ANAHEIM GENERAL HOSPITAL ANAHEIM CA 92804	5	20	1-71	12	17	16-68	13	8	2-42	2	0	0-100	53	6	1-15	18	11	1-33	2	0	0-100	42	7	1-17	14	0	0-58
ANAHEIM MEM HOSP ANAHEIM CA 92803	20	20	16-60	14	43	18-67	39	3	3-23	15	0	0-95	147	5	3-12	79	5	1-14	12	0	0-91	305	3	3-9	81	1	0-9
ANTELOPE VALLEY HDSP MEOIC LANCASTER CA 93534	4	0	4-79	18	22	16-60	39	8	3-23	6	0	0-96	97	7	2-12	69	6	1-15	14	0	0-99	115	3	2-10	86	1	0-9
ARROYO GRANDE COMM HOSP ARROYO GRANDE CA 93420	8	0	2-60	9	11	11-68	32	6	2-24	1	0	0-100	88	7	1-12	27	11	1-25	6	0	0-96	101	5	2-11	46	0	0-14
AUBURN FAITH COMMUNITY HDS AUBURN CA 95603	10	30	8-64	10	20	10-64	49	4	3-21	2	50	0-100	135	4	2-11	54	9	1-16	20	5	0-92	103	9	2-11	83	2	0-9
AVALON MUNICIPAL HDSP AVALDN CA 90704	.	.	.	.	.	.	.	.	.	.	.	.	2	0	0-97	1	0	0-100	.	.	.	1	0	0-100	.	.	.
AVENAL DISTRICT HDSPITAL AVENAL CA 93204	3	0	2-83	.	.	.	2	0	0-98	.	.	.	5	0	0-73	3	0	1-81	.	.	.	16	6	0-34	1	0	0-100
BAKERSFIELD COMMUNITY HOSP BAKERSFIELD CA 93308	5	0	3-72	4	25	9-85	9	11	2-51	.	.	.	50	6	2-18	15	0	0-47	8	0	0-100	36	0	1-19	14	0	0-76
BALDWIN PARK COMMUNITY HOS BALDWIN PARK CA 91706	9	22	5-60	2	100	7-95	10	10	1-47	.	.	.	30	10	1-21	15	0	1-36	1	0	0-100	50	2	1-15	13	0	0-74
BARSTOW COMMUNITY HDSP BARSTOW CA 92311	2	50	1-90	4	75	4-78	13	8	1-40	3	0	0-100	44	0	1-17	47	0	1-18	3	0	0-100	47	2	1-16	24	4	0-32

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		High Risk Diagnostic Categories																							
		Overall			Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
Name/ Location	Comment/ Reference																								
BARTON MEMORIAL HOSP SOUTH LAKE TAHOE CA 95731	CA-65 *	358	11	7-16	8	0	4-59	19	26	15-55	11	36	2-47	23	4	8-42	21	33	20-60	15	20	2-42	32	13	6-33
BAY HARBOR HOSP HARBOR CITY CA 90710	CA-66 *	843	18	11-18	51	25	14-39	37	24	17-47	26	35	8-40	52	27	13-36	20	45	21-63	33	18	8-38	119	29	15-32
BEAR VALLEY COMM HOSP BIG BEAR LAKE CA 92315	CA-67 *	150	11	6-18	3	33	7-88	7	0	5-63	6	33	1-63	5	40	3-69	6	50	10-76	3	0	0-83	22	14	6-40
BELLFLOWER DOCTORS HOSPITA BELLFLOWER CA 90706	CA-68 *	362	10	7-15	24	17	13-49	10	0	7-58	13	15	4-47	20	55	11-49	4	75	6-80	13	15	5-50	35	17	7-33
BELLWOOD GEN HOSP BELLFLOWER CA 90706	CA-69	917	18	11-18	38	24	9-37	36	25	16-45	23	17	6-39	40	33	13-39	13	69	16-65	20	5	6-43	191	28	17-32
BEVERLY HILLS MED CTR LOS ANGELES CA 90035	CA-70	510	14	10-18	40	23	15-45	16	44	13-56	11	27	3-49	43	16	12-37	28	57	27-63	8	0	6-62	39	23	11-38
BEVERLY HOSPITAL MONTEBELLO CA 90640	CA-71	1884	14	10-17	119	27	16-35	90	28	20-39	41	32	10-37	152	18	18-32	76	42	27-50	43	33	12-40	175	22	14-29
BIGGS-GRIOLEY MEM HOSP GRIOLEY CA 95948	CA-72 *	293	16	9-19	21	38	13-52	10	0	10-62	6	17	3-65	13	23	8-53	12	33	16-67	8	25	2-57	55	31	12-34
BLOSS MEMORIAL HOSPITAL ATWATER CA 95301	CA-73 *	204	15	8-19	7	43	7-68	14	36	9-53	6	17	1-63	10	30	7-58	3	0	4-84	5	20	2-69	27	19	11-44
BREA COMMUNITY HOSP BREA CA 92621	CA-74	908	11	8-16	70	16	12-34	29	34	14-46	39	10	6-32	54	15	12-35	21	48	21-62	25	32	9-43	88	20	12-30
BROOKSIDE HOSP SAN PABLO CA 94806	CA-75	1658	16	10-16	106	28	16-36	76	30	18-39	71	20	8-28	126	20	15-31	57	44	28-54	51	16	8-33	121	29	13-29
BROTMAN MEDICAL CENTER CULVER CITY CA 90230	CA-76	2844	13	10-16	176	19	18-35	120	36	20-38	49	14	11-36	153	16	16-30	111	42	29-49	80	23	11-33	228	28	16-29
BUENA PARK COMMUNITY HOSPI BUENA PARK CA 90620	CA-77 *	166	17	10-22	8	0	4-60	4	25	5-79	4	0	2-75	10	0	6-57	13	77	18-67	1	100	2-98	23	17	7-40
BUENA PARK DOCTORS HOSPITA BUENA PARK CA 90620	CA-78 *	95	6	5-19	4	25	3-76	1	0	0-97	5	0	2-69	7	29	4-62	1	0	1-97	.	.	.	14	7	7-50
BURBANK COMM HOSP BURBANK CA 91501	CA-79 *	590	16	9-17	26	23	11-45	21	43	15-53	9	33	4-56	34	18	12-41	18	50	20-63	22	32	7-43	74	30	13-34
CALEXICO HOSPITAL CALEXICO CA 92231	CA-80 *	157	11	7-19	2	100	0-91	5	20	3-70	7	29	2-59	8	0	4-59	6	83	15-81	13	0	3-46	25	20	8-40
CALIFORNIA HOSPITAL MEDICA LOS ANGELES CA 90015	CA-81	1531	15	10-17	126	33	16-34	86	21	19-39	40	20	8-34	133	12	16-31	65	34	27-52	49	24	9-35	134	26	14-29
CAMARILLO STATE HOSP CAMARILLO CA 93010	CA-82	44	7	2-21	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	2	100	4-92	12	8	3-46
CANOGA PARK HOSPITAL CANOGA PARK CA 91306	CA-83	449	21	9-18	15	33	7-50	11	36	10-61	11	27	3-50	19	21	9-47	21	52	24-65	12	25	3-48	65	40	13-35
CARE UNIT BEHAVIORAL CTR O LOS ANGELES CA 90016	CA-84 *	8	0	0-66	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	
CEDARS-SINAI MEDICAL CENTE LOS ANGELES CA 90048	CA-85	7682	10	9-16	801	22	18-31	221	24	23-37	212	18	13-29	405	14	20-30	301	25	35-49	97	15	10-30	433	20	17-28
CENTINELA HOSPITAL MEDICAL INGLEWOOD CA 90301	CA-86	1947	10	7-14	135	31	17-36	70	31	17-38	60	7	8-30	88	15	15-33	39	36	23-53	45	16	8-34	106	14	12-28
CENTURY CITY HOSPITAL LOS ANGELES CA 90067	CA-87 *	784	6	8-15	41	22	14-43	20	15	13-52	18	6	5-42	24	13	11-46	9	0	17-74	18	6	5-43	65	11	12-33
CENTURY COMM HOSP LOS ANGELES CA 90003	CA-88 *	107	33	10-26	1	0	0-97	19	68	11-51	4	75	4-77	9	22	3-54	10	60	18-73	1	0	0-99	14	36	4-44
CHANNEL ISLANDS COMMUNITY OXNARO CA 93030	CA-89	224	13	7-18	7	43	4-63	8	25	7-65	5	60	1-68	4	75	4-77	8	25	18-79	7	14	2-59	27	30	10-41
CHAPMAN GENERAL HOSP INC ORANGE CA 92669	CA-90 *	323	11	7-16	30	37	10-41	9	22	7-61	10	20	4-53	11	18	7-55	12	8	18-69	7	14	2-59	32	19	8-36

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

CA-4

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
BARTON MEMORIAL HOSP SOUTH LAKE TAHOE CA 95731	2	0	1-90	1	0	2-98	18	6	1-32	.	.	.	21	10	0-28	2	0	0-98	.	.	.	46	4	1-15	33	0	0-26
BAY HARBOR HOSP HARBOR CITY CA 90710	10	30	6-60	20	35	19-61	26	12	2-28	2	0	0-100	61	11	2-16	40	15	3-23	5	0	0-100	42	12	1-18	49	0	0-14
BEAR VALLEY COMM HOSP BIG BEAR LAKE CA 92315	.	.	.	3	100	3-83	1	0	0-100	.	.	.	18	0	0-32	1	0	0-98	5	0	0-100	15	7	0-37	5	0	0-97
BELLFLOWER DOCTORS HOSPITA BELLFLOWER CA 90706	7	29	3-65	2	0	2-90	5	0	0-71	5	0	0-100	29	0	0-22	28	4	0-27	9	0	0-100	25	8	1-24	18	0	0-64
BELLWOOD GEN HOSP BELLFLOWER CA 90706	11	36	9-63	40	53	21-54	30	13	4-29	1	0	0-100	77	6	2-14	48	2	1-18	13	0	0-97	64	5	2-14	38	0	0-18
BEVERLY HILLS MEO CTR LOS ANGELES CA 90035	1	0	0-100	4	50	14-90	14	7	1-38	10	0	0-100	20	10	1-30	22	5	1-29	2	0	0-100	40	8	2-19	39	3	0-18
BEVERLY HOSPITAL MONTEBELLO CA 90640	8	63	8-68	27	48	18-55	47	2	3-22	2	0	0-100	190	4	3-11	92	11	3-16	21	5	0-32	219	5	2-9	134	2	0-7
BIGGS-GRIOLEY MEM HOSP GRIOLEY CA 95948	5	0	1-71	1	100	1-97	6	17	1-63	.	.	.	36	6	1-20	5	0	0-85	4	0	0-100	24	4	0-25	11	0	0-62
BLOSS MEMORIAL HOSPITAL ATWATER CA 95301	.	.	.	6	67	12-79	11	9	1-44	2	0	0-100	13	0	0-40	8	0	2-54	3	0	0-100	21	14	1-27	13	0	0-68
BREA COMMUNITY HOSP BREA CA 92621	16	13	6-52	12	17	19-71	16	6	2-36	2	0	0-100	88	10	2-12	53	6	1-17	14	0	0-95	77	1	2-13	69	4	0-11
BROOKSIDE HOSP SAN PABLO CA 94806	13	31	10-61	24	38	20-59	33	18	4-28	4	0	0-100	118	10	2-11	91	8	2-15	18	6	0-44	125	6	2-10	79	3	0-9
BROTMAN MEICAL CENTER CULVER CITY CA 90230	13	15	8-58	35	43	20-54	51	12	4-22	13	0	0-90	199	6	3-11	163	6	3-13	5	0	0-100	248	6	3-9	143	2	0-6
BUENA PARK COMMUNITY HOSPI BUENA PARK CA 90620	6	50	6-72	2	50	7-96	4	0	1-73	.	.	.	22	14	1-28	3	33	0-81	.	.	.	18	0	0-31	5	0	0-98
BUENA PARK DOCTORS HOSPITA BUENA PARK CA 90620	.	.	.	.	.	.	2	0	0-91	.	.	.	3	0	0-94	3	0	0-97	.	.	.	8	0	0-58	8	0	0-90
BURBANK COMM HOSP BURBANK CA 91501	5	20	5-75	11	45	14-67	23	9	2-29	1	0	0-100	42	12	1-18	44	7	2-20	7	0	0-84	43	9	1-16	57	0	0-14
CALEXICO HOSPITAL CALEXICO CA 92231	2	50	2-90	2	0	2-90	1	0	0-100	.	.	.	16	6	1-34	6	17	0-68	.	.	.	14	0	0-38	3	0	0-99
CALIFORNIA HOSPITAL MEDICA LOS ANGELES CA 90015	9	22	9-67	16	19	17-64	34	12	3-25	7	0	0-100	106	7	2-12	67	4	2-16	9	0	0-100	94	9	1-11	93	1	0-9
CAMARILLO STATE HOSP CAMARILLO CA 93010	1	0	0-100	.	.	.	.	.	.	.	.	.	1	0	0-100	3	0	0-93	.	.	.	.	.	.	4	0	0-100
CANOGA PARK HOSPITAL CANOGA PARK CA 91306	8	13	3-61	8	38	12-72	16	13	1-35	2	0	0-100	27	15	0-23	28	7	3-27	4	0	0-100	35	3	1-19	9	22	0-84
CARE UNIT BEHAVIORAL CTR O LOS ANGELES CA 90016	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	1	0	0-100	
CECARS-SINAI MEICAL CENTE LOS ANGELES CA 90048	69	10	10-40	71	35	26-52	203	8	5-15	60	0	0-19	522	3	4-9	520	3	2-9	60	0	0-31	770	4	3-7	529	2	1-4
CENTINELA HOSPITAL MEDICAL INGLEWOOD CA 90301	15	33	7-54	17	35	20-65	39	8	2-22	7	0	0-100	157	7	3-11	104	9	2-13	16	0	0-78	114	7	2-11	279	2	0-4
CENTURY CITY HOSPITAL LOS ANGELES CA 90067	11	9	3-53	10	40	16-72	18	0	2-34	31	0	0-57	59	2	2-17	56	5	1-16	5	0	0-100	58	2	2-16	51	2	0-13
CENTURY COMM HOSP LOS ANGELES CA 90003	.	.	.	4	50	5-79	.	.	.	.	.	.	5	20	0-81	3	33	0-83	.	.	.	9	0	0-60	1	0	0-100
CHANNEL ISLANDS COMMUNITY OXNARO CA 93030	4	25	6-81	1	100	0-97	5	0	0-70	4	0	0-100	20	15	1-29	6	0	0-72	2	0	0-100	11	9	0-45	15	0	0-47
CHAPMAN GENERAL HOSP INC ORANGE CA 92669	3	0	0-84	1	0	0-97	7	0	0-59	1	0	0-100	34	3	1-19	19	11	1-31	10	0	0-87	20	5	0-29	17	0	0-53

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		High Risk Diagnostic Categories																									
		Overall			Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease				
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent		
Name/ Location	Comment/ Reference	CHARTER COMM HOSP HAWAIIAN GARDENS CA 90716	CA-91 *	190	12	4-14	9	11	1-52	9	22	7-61	2	0	0-94	11	18	4-51	3	33	4-84	7	14	2-59	20	15	4-37
CHARTER SUBURBAN HOSP PARAMOUNT CA 90723	CA-92	595	17	10-18	13	23	7-52	28	25	14-47	12	42	4-49	38	26	11-37	31	58	22-55	15	33	6-48	87	22	10-28		
CHICO COMM MEM HOSP CHICO CA 95926	CA-93	857	10	6-14	58	19	10-33	20	30	14-53	19	32	6-42	18	39	9-47	16	50	18-63	6	17	1-63	82	23	13-33		
CHILDRENS HOSP AND HEALTH SAN DIEGO CA 92123	CA-94 *	1	0	0-100	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.		
CHILDRENS HOSPITAL OF SAN SAN FRANCISCO CA 94118	CA-95	1379	11	8-15	184	23	15-31	54	28	16-40	25	12	6-39	62	21	15-37	46	35	25-54	18	11	4-41	109	21	11-27		
CHINESE HOSP SAN FRANCISCO CA 94133	CA-96 *	497	15	11-19	37	30	10-38	32	9	14-45	25	20	9-43	33	12	14-45	16	31	22-68	22	23	7-43	56	27	14-37		
CHINO GENERAL HOSPITAL CHINO CA 91710	CA-97 *	610	10	8-16	29	24	14-47	23	26	14-50	19	21	6-43	42	21	12-38	18	39	19-62	16	31	7-49	50	16	10-33		
CHOWCHILLA DISTRICT MEM HO CHOWCHILLA CA 93610	CA-98 *	145	15	9-22	8	75	11-71	4	0	4-77	4	25	1-74	13	15	7-51	6	33	9-75	7	0	3-62	23	17	8-41		
CHRISTIAN HOSP MEO CTR PERRIS CA 92370	CA-99	727	16	10-17	22	23	8-44	37	51	15-44	22	14	3-35	51	29	13-36	57	44	25-51	26	12	7-40	61	31	12-34		
CHURCH OF ST MATTHEWS MILL SAN MATEO CA 94401	CA-100*	2201	11	8-15	204	25	15-31	104	30	20-39	53	11	10-33	112	20	16-33	62	35	26-52	30	13	6-36	130	18	12-27		
CIRCLE CITY HOSPITAL CORONA CA 91719	CA-101	889	9	8-15	60	28	13-38	23	22	14-51	18	6	7-45	41	22	11-37	18	44	20-63	31	19	8-39	81	15	13-32		
CITY OF HOPE NATIONAL MEO QUARTE CA 91010	CA-102*	596	21	19-28	226	27	26-43	7	29	6-66	24	33	15-52	9	33	9-64	9	33	17-74	15	33	20-67	62	18	12-33		
CLOVIS COMMUNITY HOSP CLOVIS CA 93612	CA-103	231	14	8-19	8	38	4-59	12	25	11-59	5	0	1-68	11	27	5-52	11	18	17-70	9	22	3-55	39	21	9-34		
COALINGA DISTRICT HOSPITAL COALINGA CA 93210	CA-104*	117	15	9-23	4	50	8-84	3	33	5-86	2	0	0-95	8	38	8-65	2	50	5-93	5	40	2-69	26	8	9-41		
COAST PLAZA MEDICAL CTR NORWALK CA 90650	CA-105*	666	16	10-18	59	24	14-38	22	27	13-51	16	31	4-43	47	21	11-35	13	38	19-68	27	22	7-39	81	27	14-34		
COASTAL COMMUNITIES HOSP SANTA ANA CA 92704	CA-106	594	16	10-18	29	21	13-46	19	21	14-55	13	15	6-51	39	28	14-41	22	68	26-66	16	13	5-45	90	23	14-33		
COMM HOSP OF THE MONTEREY MONTEREY CA 93940	CA-107	2718	13	9-15	309	19	15-29	110	44	19-37	72	14	10-31	124	26	15-31	97	29	30-50	35	23	7-35	140	19	15-31		
COMM MEM HOSP OF SAN BUENA VENTURA CA 93003	CA-108*	1924	10	8-15	187	18	16-32	62	24	19-42	59	20	10-33	61	26	13-34	95	33	28-48	24	21	9-44	117	17	13-30		
COMMUNITY HOSPITAL OF SACRA SACRAMENTO CA 95815	CA-109	368	8	6-14	9	22	7-61	8	0	6-63	4	0	1-74	16	38	8-49	17	59	18-62	10	10	3-52	35	11	7-33		
COMMUNITY HOSP LOS GATOS S LOS GATOS CA 95030	CA-110	1103	12	10-17	93	11	12-32	38	42	17-47	32	9	11-42	57	21	13-35	42	48	29-59	35	20	8-38	89	31	14-32		
COMMUNITY HOSP OF CHULA VI CHULA VISTA CA 92010	CA-111*	1336	12	9-16	106	29	18-38	38	21	13-41	36	14	7-34	82	17	15-34	42	45	25-55	35	17	8-37	107	20	14-31		
COMMUNITY HOSP OF HUNTINGT HUNTINGTON PARK CA 90255	CA-112*	254	11	7-17	18	39	16-58	1	0	0-97	5	20	3-70	17	12	10-50	4	25	8-83	7	14	2-60	24	13	8-41		
COMMUNITY HOSP OF SAN GABR SAN GABRIEL CA 91776	CA-113*	2063	13	10-17	157	34	18-36	80	18	19-40	48	10	6-30	130	20	17-32	62	44	28-53	68	15	11-34	229	27	16-30		
COMMUNITY HOSPITAL SANTA ROSA CA 95404	CA-114	1029	12	9-16	59	31	12-36	45	27	18-45	17	24	8-49	47	17	14-39	36	36	23-55	27	7	8-40	93	16	11-29		
COMMUNITY HOSPITAL OF GARD GARDENA CA 90247	CA-115	320	19	11-21	36	36	13-44	22	14	16-55	10	10	4-53	25	40	13-47	7	29	14-77	5	20	2-69	40	35	12-39		
COMMUNITY HOSPITAL OF SALI SALINAS CA 93905	CA-116*	173	13	5-16	4	25	3-76	2	0	1-89	5	20	1-68	7	14	3-61	6	83	14-80	3	0	0-89	15	13	3-41		

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

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HOSPITALS	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
Name/ Location																											
CHARTER COMM HOSP HAWAIIAN GAROENS CA 90716	3	67	1-83				3	0	0-92				16	0	0-41	13	0	0-52	1	0	0-100	21	10	0-28	8	13	0-91
CHARTER SUBURBAN HOSP PARAMOUNT CA 90723	2	0	0-96	20	35	16-57	27	0	3-29				52	10	1-15	32	6	1-23	4	0	0-94	46	4	1-17	28	0	0-26
CHICO COMM MEM HOSP CHICO CA 95926	5	20	4-74	8	0	11-71	38	11	3-24	8	0	0-99	70	10	2-14	34	3	0-22	19	0	0-98	34	6	1-21	84	1	0-9
CHILDRENS HOSP AND HEALTH SAN OIEGO CA 92123																									1	0	0-100
CHILORENS HOSPITAL OF SAN SAN FRANCISCO CA 94118	8	25	2-60	3	33	4-85	52	6	3-21	11	0	0-99	90	7	2-12	65	3	1-15	18	0	0-96	55	7	2-15	183	1	0-5
CHINESE HOSP SAN FRANCISCO CA 94133	5	60	4-73	11	27	12-65	15	0	1-37	3	0	0-100	40	3	1-18	28	0	0-25	4	0	0-100	17	0	1-32	32	6	0-22
CHINO GENERAL HOSPITAL CHINO CA 91710	5	20	3-72	4	50	3-77	14	7	2-40	3	0	0-100	58	2	2-16	29	3	1-24	13	0	0-96	70	0	1-12	41	2	0-19
CHOWCHILLA DISTRICT MEM HO CHOWCHILLA CA 93610	1	100	1-97	3	33	2-82	4	0	0-78				16	0	0-35	5	0	1-67				30	10	1-21	3	0	0-100
CHRISTIAN HOSP MEO CTR PERRIS CA 92370	6	33	4-69	5	60	11-82	36	3	2-23				49	2	1-16	32	3	1-23	3	0	0-100	96	3	2-11	24	4	0-24
CHURCH OF ST MATTHEWS MILL SAN MATEO CA 94401	8	25	6-65	22	18	17-57	92	8	4-17	19	0	0-82	215	7	3-10	90	1	1-13	24	4	0-33	104	5	2-12	188	3	0-5
CIRCLE CITY HOSPITAL CORONA CA 91719	9	33	7-64	3	0	4-84	17	12	2-36				80	4	2-14	23	0	1-28	11	9	0-72	84	2	2-12	127	0	0-7
CITY OF HOPE NATIONAL MED DUARTE CA 91010	6	83	6-71	9	33	16-74							36	17	6-30	10	0	0-47	2	0	0-95	34	0	2-21	13	23	2-42
CLOVIS COMMUNITY HOSP CLOVIS CA 93612	3	33	1-82	3	33	5-86	14	14	1-38				22	9	1-27	5	0	0-84				23	9	1-25	10	0	0-86
COALINGA DISTRICT HOSPITAL COALINGA CA 93210	5	40	3-72	1	0	0-97							8	13	0-55	3	67	2-81				10	0	0-56	2	0	0-100
COAST PLAZA MEDICAL CTR NORWALK CA 90650	9	56	8-66	9	44	17-75	18	17	2-35				71	10	2-15	31	6	2-24	10	0	0-100	56	4	1-15	22	0	0-37
COASTAL COMMUNITIES HOSP SANTA ANA CA 92704	9	22	3-59	7	43	12-75	11	9	0-45	2	0	0-100	49	4	1-16	47	2	2-19	4	0	0-99	33	9	1-21	37	0	0-22
COMM HOSP OF THE MONTEREY MONTEREY CA 93940	17	18	9-54	24	33	17-56	100	9	5-18	39	0	0-31	226	8	3-10	104	2	1-12	27	0	0-50	209	8	3-9	253	3	1-5
COMM MEM HOSP OF SAN BUENA VENTURA CA 93003	11	0	6-59	8	13	9-68	51	8	3-20	18	0	0-84	164	2	2-10	70	4	1-15	34	0	0-80	207	5	2-8	233	1	0-5
COMMUNITY HOSPITAL OF SACRA SACRAMENTO CA 95815	1	0	0-99	2	100	4-93	14	0	0-38				23	4	0-28	13	0	1-40	2	0	0-100	21	5	1-27	22	0	0-65
COMMUNITY HOSP LOS GATOS S LOS GATOS CA 95030	10	20	7-62	11	27	13-66	55	7	3-21	19	0	0-82	89	6	2-13	61	3	1-16	11	0	0-94	76	11	2-13	68	0	0-10
COMMUNITY HOSP OF CHULA VI CHULA VISTA CA 92010	7	29	1-63	19	32	16-58	42	7	3-23	3	0	0-100	146	3	2-10	86	3	1-13	12	0	0-99	112	7	2-11	81	2	0-9
COMMUNITY HOSP OF HUNTINGT HUNTINGTON PARK CA 90255	2	50	2-90	5	60	9-80							31	3	1-21	11	0	0-47	5	0	0-100	28	0	1-22	10	0	0-93
COMMUNITY HOSP OF SAN GABR SAN GABRIEL CA 91776	22	18	6-46	32	28	21-56	71	4	3-18	42	0	0-46	166	10	3-11	97	2	1-13	16	0	0-70	221	3	3-9	120	0	0-7
COMMUNITY HOSPITAL SANTA ROSA CA 95404	10	30	8-63	13	46	12-61	26	4	3-29	2	0	0-100	72	4	2-15	21	5	0-29	10	10	0-95	95	6	2-12	34	0	0-19
COMMUNITY HOSPITAL OF GARO GARONA CA 90247	3	67	0-84	7	14	7-68	7	0	1-57	1	0	0-100	38	18	2-21	26	0	0-26	2	0	0-100	12	0	0-42	14	7	0-56
COMMUNITY HOSPITAL OF SALI SALINAS CA 93905	1	0	1-97	2	100	4-92	3	33	2-82				19	5	1-31	11	9	0-51	3	0	0-100	17	0	0-33	14	0	0-90

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		High Risk Diagnostic Categories																											
		Overall			Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease						
Name/Location	Comment/Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	
CORCORAN DISTRICT HOSP CORCORAN CA 93212	CA-117*	104	11	6-20	1	0	0-99	2	0	2-90	1	0	0-98	10	40	6-56	5	40	11-81	8	13	1-56	17	12	5-43				
CORNING MEM HOSP CORNING CA 96021	CA-118*	99	14	6-20	1	0	0-97	2	0	1-89	2	0	0-92	16	44	6-45	2	50	2-89	9	0	2-53	13	31	4-46				
CORONA COMMUNITY HOSP CORONA, CA 91720	CA-119	842	14	9-17	46	24	14-41	48	38	18-45	32	16	7-36	39	21	12-39	14	36	16-64	36	28	12-43	86	28	14-34				
CORONADO HOSP CORONADO CA 92118	CA-120*	584	11	9-17	44	25	12-39	20	20	12-51	23	9	7-40	43	23	14-40	17	35	17-61	8	0	2-56	56	18	11-33				
COSTA MESA MEO CTR HOSP COSTA MESA CA 92627	CA-121*	399	17	9-18	20	35	10-48	9	44	13-69	13	15	5-48	18	28	10-49	14	43	20-68	26	31	5-37	48	27	11-36				
COVINA VALLEY COMMUNITY HO WEST COVINA CA 91791	CA-122	570	14	9-17	17	53	16-60	16	6	10-52	13	46	6-50	31	23	12-42	8	25	18-78	16	13	4-44	100	21	13-31				
CRENSHAW CENTER HOSPITAL LOS ANGELES CA 90008	CA-123*	139	9	6-18	4	25	2-75	11	27	10-61	4	25	1-74	10	30	5-54	1	0	2-98	4	0	2-75	9	11	3-53				
CAMERON HOSP STOCKTON CA 95203	CA-124*	1655	14	10-17	106	22	13-33	57	35	17-41	48	17	8-32	108	19	15-32	70	43	28-53	53	21	9-34	137	24	15-30				
DANIEL FREEMAN MARINA HOSP MARINA DEL REY CA 90291	CA-125	870	14	8-16	28	29	14-48	41	41	17-45	13	8	5-50	45	24	11-36	38	50	25-56	21	29	10-47	70	16	8-27				
DANIEL FREEMAN MEMORIAL HO INGLEWOOD CA 90301	CA-126	2861	13	10-16	218	34	20-36	118	31	21-39	50	20	9-33	183	20	17-30	102	35	28-48	93	24	12-33	189	22	15-29				
DEL PUERTO HOSP PATTERSON CA 95363	CA-127*	108	7	5-19	1	100	2-98	3	33	3-82	3	0	1-81	4	25	2-74				9	22	5-59	14	7	5-47				
OELANO REGIONAL MEDICAL CT OELANO CA 93215	CA-128*	704	10	11-18	28	14	19-55	14	21	14-61	7	0	1-58	37	14	12-40	22	41	23-63	36	17	12-42	111	18	16-33				
OELTA MEMORIAL HOSP ANTIOCH CA 94509	CA-129*	706	16	9-17	45	9	8-33	33	36	20-52	16	6	4-42	57	46	14-37	23	30	20-58	13	38	8-54	87	23	11-29				
DESERT HOSPITAL CORP PALM SPRINGS CA 92262	CA-130	2987	10	8-15	251	22	17-33	101	28	21-40	79	16	8-27	103	22	17-35	98	42	28-49	47	30	12-40	177	18	14-28				
DOCTOR'S MEDICAL CENTER MOORESTOWN NJ 08050	CA-131	2588	9	7-14	173	21	15-32	72	42	18-39	40	15	5-30	120	19	14-30	93	27	27-48	35	17	8-38	152	18	13-27				
DOCTORS HOSP OF LAKEWOOD C LAKEWOOD CA 90712	CA-132*	72	1	2-15				2	0	1-89												1	0	0-98					
DOCTORS HOSP OF MONTCLAIR MONTCLAIR CA 91763	CA-133*	625	14	9-17	21	14	9-46	28	25	16-49	20	20	5-39	44	30	11-35	26	46	21-57	21	38	4-39	92	24	12-30				
DOCTORS HOSPITAL OF LAKEWO LAKEWOOD CA 90712	CA-134	1494	17	10-17	124	30	15-34	54	41	19-44	43	33	9-34	101	29	14-32	77	43	28-51	40	20	11-40	162	22	14-29				
DOCTORS HOSPITAL OF MANTEC MANTECA CA 95336	CA-135*	505	14	9-18	21	10	10-47	25	20	13-48	14	14	4-46	30	30	11-41	24	38	20-58	28	21	14-49	56	25	10-32				
DOCTORS HOSPITAL OF PINOLE PINOLE CA 94564	CA-136	1124	10	8-15	90	24	13-34	54	26	19-44	28	43	7-38	55	11	14-37	20	40	18-59	24	21	5-38	96	18	11-29				
DOCTORS HOSPITAL OF SANTA SANTA ANA CA 92706	CA-137*	419	16	8-17	13	23	7-53	8	63	11-69	9	33	3-55	29	17	10-40	7	14	11-73	15	27	5-46	74	32	13-33				
DOMINGUEZ MEDICAL CTR LONG BEACH, CA 90805	CA-138	735	12	7-15	20	35	12-51	26	31	12-46	19	16	4-40	54	17	11-33	15	40	18-64	27	7	6-38	67	18	10-30				
DOMINICAN SANTA CRUZ HOSP SANTA CRUZ CA 95065	CA-139*	2287	13	10-17	170	30	16-33	130	25	19-36	96	17	9-28	111	23	17-34	87	37	30-52	68	13	11-34	222	19	14-27				
DONALD N SHARP MEM COMM HO SAN DIEGO CA 92123	CA-140*	2814	10	8-14	226	21	17-33	75	31	19-41	56	20	7-30	94	21	15-32	63	30	25-49	41	27	12-41	190	26	14-28				
DOS PALOS MEM HOSPITAL DOS PALOS CA 93620	CA-141*	22	9	3-32										2	0	1-89				4	25	2-74	3	0	0-88				
DOWNEY COMMUNITY HOSPITAL DOWNEY CA 90241	CA-142	2174	14	10-16	222	27	16-32	105	32	20-39	62	11	11-33	112	28	16-32	79	51	26-49	31	19	9-40	207	19	13-26				

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

CA-8

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
CORCORAN DISTRICT HOSP CORCORAN CA 93212	3	33	5-86							1	0	0-100	9	0	0-60	1	0	0-98	2	0	0-100	15	0	0-36	2	0	0-100
CORNING MEM HDSP CORNING CA 96021	3	0	2-83				3	0	0-87				7	0	1-57	5	0	0-80				18	6	0-31	2	0	0-100
CORONA COMMUNITY HDSP CORONA, CA 91720	5	0	2-71	8	38	7-66	23	13	2-29				58	22	2-16	32	3	1-22	6	0	0-100	68	12	2-14	103	0	0-8
CORONADO HDSP CORONADO CA 92118	8	25	8-69	12	25	12-63	30	13	3-27				52	4	1-16	23	0	1-27	3	0	0-100	49	0	1-15	29	3	0-21
COSTA MESA MED CTR HOSP COSTA MESA CA 92627	5	60	5-75	5	0	8-78	14	14	3-41				33	3	2-22	17	0	2-35	7	0	0-100	26	4	1-24	24	4	0-27
COVINA VALLEY COMMUNITY HO WEST COVINA CA 91791	17	35	10-56	8	25	11-70	10	0	0-48	1	0	0-100	78	5	2-13	35	0	2-22	9	0	0-100	44	5	1-17	13	0	0-92
CRENSHAW CENTER HOSPITAL LDS ANGELES CA 90008	3	33	4-85				3	0	0-89				8	0	1-53	4	0	0-96				6	0	0-63	15	0	0-79
DAMERDN HOSP STOCKTON CA 95203	17	41	9-54	32	44	25-61	64	8	4-20	28	0	0-70	137	4	3-12	98	2	1-12	33	0	0-30	166	6	2-9	60	2	0-13
DANIEL FREEMAN MARINA HOSP MARINA DEL REY CA 90291	10	10	4-57	11	55	14-67	28	18	2-26				64	5	2-15	38	5	1-21	2	0	0-100	77	5	2-14	65	5	0-12
DANIEL FREEMAN MEMORIAL HO INGLEWOOD CA 90301	18	22	9-53	36	61	20-53	61	8	5-22	32	0	0-42	226	6	3-11	104	9	2-14	13	0	0-96	326	4	3-8	154	2	0-6
DEL PUERTO HDSP PATTERSON CA 95363	3	0	6-88				1	0	0-100				15	0	0-36	2	0	0-98				8	0	0-62	8	13	0-86
DELANO REGIONAL MEDICAL CT DELANO CA 93215	14	7	8-56	6	0	7-72	9	11	6-58				74	1	2-14	69	3	1-15	2	0	0-100	104	4	2-12	13	0	0-53
DELTA MEMORIAL HDSP ANTIOCH CA 94509	2	50	1-90	11	36	15-68	25	12	1-27	6	0	0-100	58	12	2-15	41	2	1-20	9	0	0-99	39	5	1-18	47	4	0-16
DESERT HOSPITAL CORP PALM SPRINGS CA 92262	17	12	8-52	13	23	15-65	71	11	4-19	37	3	0-44	242	5	3-10	147	5	2-12	17	0	0-61	321	4	3-8	182	2	0-5
DOCTOR'S MEDICAL CENTER MODESTO CA 95350	16	19	10-57	15	27	17-64	59	5	3-19	19	5	0-90	212	5	3-11	120	3	1-12	17	0	0-84	619	3	3-7	157	2	0-6
DOCTORS HDSP OF LAKEWOOD C LAKEWOOD CA 90712																1	0	0-100							1	0	0-100
DOCTORS HOSP OF MONTCLAIR MONTCLAIR CA 91763	4	0	6-81	10	60	11-66	11	9	1-44	2	0	0-100	49	0	1-17	46	7	2-20	7	0	0-100	55	2	1-15	26	0	0-25
DOCTORS HOSPITAL OF LAKEWO LAKEWOOD CA 90712	15	40	7-53	15	53	22-70	36	11	4-27	4	0	0-100	120	9	2-12	108	6	1-12	14	0	0-95	132	3	2-10	72	4	0-11
DOCTORS HOSPITAL OF MANTEC MANTECA CA 95336	6	0	6-72	6	50	11-78	12	17	1-43	6	0	0-100	45	2	1-17	20	5	1-30	2	0	0-100	47	4	1-16	27	0	0-28
DOCTORS HOSPITAL OF PINOLE PINOLE CA 94564	7	29	4-66	11	36	13-66	36	6	2-23	1	0	0-100	78	4	2-13	57	4	1-16	13	0	0-100	73	1	1-12	115	3	0-7
DOCTORS HOSPITAL OF SANTA SANTA ANA CA 92706	3	0	4-85	8	13	9-68	10	10	0-48	1	0	0-100	50	12	1-16	39	13	2-23	5	0	0-100	23	0	1-25	16	0	0-69
DOMINGUEZ MEDICAL CTR LONG BEACH, CA 90805	8	25	10-72	4	50	6-81	7	14	1-58	1	0	0-100	39	10	2-20	32	9	1-23	2	0	0-100	86	2	1-11	16	13	0-63
DOMINICAN SANTA CRUZ HDSP SANTA CRUZ CA 95065	20	25	9-52	44	39	24-55	72	6	3-18	12	0	0-99	180	9	3-11	91	3	1-13	32	0	0-74	160	6	2-10	167	2	0-6
DONALD N SHARP MEM COMM HO SAN DIEGO CA 92123	20	15	9-51	21	48	17-58	65	11	3-18	2	0	0-100	224	6	3-11	118	1	1-12	48	0	0-33	560	4	3-7	204	3	0-5
DOS PALMS MEM HOSPITAL DOS PALMS CA 93620	1	0	0-99													1	0	0-100				2	50	0-91			
DOWNEY COMMUNITY HOSPITAL DOWNEY CA 90241	25	20	9-48	26	38	20-58	74	7	4-18	22	0	0-94	217	5	2-9	124	5	2-12	43	0	0-50	124	5	2-10	156	1	0-6

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		High Risk Diagnostic Categories																							
		Overall			Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
Name/Location	Comment/Reference																								
EAST BAY HOSP RICHMDND CA 94804	CA-143*	125	2	1-12	1	100	3-99													1	0	0-97	2	0	1-89
EAST LOS ANGELES DOCTORS H LDS ANGELES CA 90023	CA-144*	431	8	8-16	18	22	14-56	5	20	5-73	9	33	14-71	24	25	13-48	4	25	6-80	16	6	3-41	39	10	11-39
EASTERN PLUMAS DISTRICT HD PORTDLA CA 96122	CA-145*	94	5	4-18	6	0	2-64				3	33	1-82	3	0	2-81	4	25	8-83	5	20	1-68	9	0	2-52
EDEN HOSPITAL CASTRO VALLEY CA 94546	CA-146*	1843	12	9-15	154	31	17-35	64	34	18-41	21	19	6-41	115	18	16-32	44	55	26-55	35	20	6-34	123	21	13-29
EISENHOWER MED CTR RANCHO MIRAGE CA 92260	CA-147*	3129	7	7-14	269	24	16-31	92	17	19-39	64	5	8-30	99	17	16-34	83	24	26-48	51	12	8-33	179	10	12-25
EL CAMINO HOSP MOUNTAIN VIEW CA 94042	CA-148	2886	11	9-15	288	20	16-31	132	36	20-37	72	18	8-29	130	23	16-31	118	36	31-50	52	12	7-32	163	23	12-27
EL CENTRD REGIONAL MED CTR EL CENTRD CA 92243	CA-149*	874	14	10-18	60	27	14-39	44	25	17-44	16	13	6-45	42	21	12-38	36	44	21-52	40	20	9-37	115	22	12-28
EMANUEL MEDICAL CENTER INC TURLOCK CA 95380	CA-150*	1618	12	10-16	96	27	15-35	61	25	19-42	34	15	8-37	97	27	15-32	63	29	26-51	47	11	8-34	160	21	15-29
ENCINO HOSP ENCINO CA 91436	CA-151*	1108	9	8-15	109	35	16-36	20	25	15-55	20	10	5-41	30	20	10-40	35	23	22-53	16	19	5-46	63	24	14-37
ESKATON COLUSA HEALTHCARE COLUSA CA 95932	CA-152*	250	16	8-19	19	42	8-47	8	38	8-65	12	50	5-50	13	8	7-52	12	67	16-67	3	33	3-83	34	21	9-36
ESTELLE DOHENY EYE HOSPITA LOS ANGELES, CA 90033	CA-153*	344	1	0-18	9	0	2-53																		
FALLBROOK HOSP FALLBROOK CA 92028	CA-154*	713	12	8-15	41	17	9-36	40	15	15-42	24	38	9-43	28	11	11-42	25	48	22-59	15	13	6-48	61	23	10-31
FEATHER RIVER HDSP PARADISE CA 95969	CA-155	1253	12	9-16	115	24	13-31	57	26	16-40	37	11	6-31	32	41	12-41	68	35	27-52	34	3	5-33	126	21	13-30
FHP-FOUNTAIN VALLEY FOUNTAIN VALLEY CA 92728	CA-156	12	0	3-45	1	0	0-97	2	0	1-89				1	0	0-97							1	0	0-97
FOOTHILL PRESBYTERIAN HOSP GLENDDORA CA 91740	CA-157	851	16	9-16	67	24	13-35	44	41	17-44	21	14	3-36	46	30	12-37	38	55	27-58	7	14	3-61	77	27	11-31
FDUNTAIN VALLEY COMM HOSP FDUNTAIN VALLEY CA 92708	CA-158*	1212	12	8-15	91	23	14-34	44	25	16-43	20	20	7-44	71	18	13-34	51	31	28-56	22	14	6-41	84	29	12-30
FOWLER MUNICIPAL HOSP FOWLER CA 93625	CA-159*	107	11	5-19	10	20	5-55	1	0	1-97	2	50	0-92	4	25	2-74	1	100	3-99	6	0	1-64	14	14	8-52
FRANK D LANTERMAN STATE HO POMONA CA 91766	CA-160*	54	2	2-18							2	0	0-95	2	0	1-89	1	0	0-97	3	0	0-86	14	0	2-41
FRANK R HOWARO MEM HOSP WILLITS CA 95490	CA-161*	255	18	8-19	16	44	8-49	15	27	11-55	7	14	3-61	20	40	9-45	6	83	14-81	11	9	5-53	25	24	9-41
FREMONT MEDICAL CENTER YUBA CITY CA 95991	CA-162*	1169	11	8-15	114	25	13-32	28	50	17-50	40	8	6-31	56	25	15-38	22	45	21-61	27	22	7-39	112	4	11-28
FRENCH HOSP LOS ANGELES CA 90012	CA-163	618	10	10-18	41	22	14-43	22	9	13-51	13	38	6-50	51	6	14-37	13	62	18-68	27	7	7-39	47	26	14-40
FRENCH HOSP SAN FRANCISCO CA 94118	CA-164	1208	9	8-15	118	14	13-32	49	22	16-42	21	19	4-37	53	11	14-38	39	33	25-55	50	10	6-31	87	25	14-33
FRENCH HOSP SAN LUIS OBISPO CA 93401	CA-165	792	10	7-14	45	22	10-37	23	39	15-52	18	44	8-47	33	24	12-41	42	24	23-52	4	25	1-74	54	24	8-29
FRESNO COMM HOSP FRESNO CA 93721	CA-166	4733	14	10-16	409	31	21-35	181	26	21-35	112	20	10-28	214	26	17-29	170	41	30-47	75	21	9-31	431	28	17-28
FULLERTON COMM HOSP FULLERTON CA 92632	CA-167*	108	19	8-22	5	0	2-69	5	60	3-70	5	20	4-71	10	30	7-57	5	80	10-80	1	0	0-98	16	38	5-44
GARFIELD MEDICAL CENTER MONTEREY PARK CA 91754	CA-168*	1010	16	11-18	45	29	14-42	49	29	17-43	24	21	7-40	72	18	14-34	50	42	26-54	38	29	7-35	99	26	15-33

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

CA-10

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
EAST BAY HOSP RICHMONO CA 94804	.	.	.	.	.	.	.	.	.	2	0	0-100	.	.	.	.	.	.	1	0	0-100	.	.	.	2	0	0-100
EAST LOS ANGELES DOCTORS H LOS ANGELES CA 90023	7	29	6-68	4	50	9-84	7	14	1-58	2	0	0-100	53	2	2-16	50	6	0-17	4	0	0-100	49	2	1-15	10	0	0-58
EASTERN PLUMAS DISTRICT HO PORTOLA CA 96122	2	50	2-90	.	.	.	.	.	.	.	.	.	7	0	0-79	2	0	0-98	.	.	.	13	0	0-44	3	0	0-100
EOEN HOSPITAL CASTRO VALLEY CA 94546	19	11	9-52	27	26	17-54	49	6	3-22	31	0	0-46	187	6	3-11	62	11	1-16	8	0	0-100	96	5	2-12	159	0	0-6
EISENHOWER MED CTR RANCHO MIRAGE CA 92260	22	18	12-54	15	27	16-63	61	8	3-18	17	0	0-93	230	5	2-9	147	1	1-11	27	0	0-60	470	2	3-7	306	0	1-5
EL CANINO HOSP MOUNTAIN VIEW CA 94042	22	27	9-50	18	11	15-59	104	7	4-17	14	0	0-85	274	5	2-9	131	2	1-11	46	0	0-36	260	3	3-8	225	2	0-5
EL CENTRO REGIONAL MEO CTR EL CENTRO CA 92243	15	20	9-57	18	39	19-64	27	7	2-26	1	0	0-100	99	8	2-12	46	9	2-19	5	0	0-100	62	5	2-14	42	0	0-19
EMANUEL MEDICAL CENTER INC TURLOCK CA 95380	14	43	9-58	18	28	15-58	53	6	5-24	5	0	0-99	165	8	3-12	69	3	2-16	17	0	0-90	159	4	2-9	96	2	0-8
ENCINO HOSP ENCINO CA 91436	6	0	6-72	4	50	5-80	35	3	5-29	39	0	0-35	75	3	2-14	45	2	2-20	3	0	0-100	205	5	3-9	94	1	0-8
ESKATON COLUSA HEALTHCARE COLUSA CA 95932	2	50	1-90	1	100	3-99	8	0	0-55	.	.	.	14	0	0-38	12	0	0-44	.	.	.	27	0	1-23	17	0	0-72
ESTELLE OOHENY EYE HOSPITA LOS ANGELES, CA 90033	.	.	.	.	.	.	.	.	.	310	0	0-3	.	.	.	.	.	.	.	.	.	2	50	0-97	.	.	.
FALLBROOK HOSP FALLBROOK CA 92028	6	67	8-74	3	33	8-90	24	0	1-27	2	50	0-100	70	7	2-14	48	0	0-18	9	0	0-100	56	5	1-14	54	2	0-13
FEATHER RIVER HOSP PARAIOSE CA 95969	13	8	8-58	10	20	11-65	44	2	2-20	1	0	0-100	106	5	2-12	66	2	0-15	14	0	0-93	95	8	3-13	94	3	0-8
FHP-FOUNTAIN VALLEY FOUNTAIN VALLEY CA 92728	.	.	.	.	.	.	.	.	.	.	.	.	1	0	0-97	1	0	0-100	.	.	.	.	.	.	.	.	.
FOOTHILL PRESBYTERIAN HOSP GLENORA CA 91740	11	9	3-54	7	71	14-77	31	0	2-25	5	0	0-100	62	10	1-15	55	9	2-18	11	0	0-93	87	5	2-12	41	2	0-17
FOUNTAIN VALLEY COMM HOSP FOUNTAIN VALLEY CA 92708	10	50	5-58	18	33	16-60	42	2	2-22	6	0	0-100	124	10	2-11	30	0	1-23	17	6	0-69	164	4	2-9	92	1	0-9
FOWLER MUNICIPAL HOSP FOWLER CA 93625	1	0	3-99	.	.	.	5	0	0-75	.	.	.	20	10	0-32	8	0	0-63	5	0	0-100	.	.	.	5	0	0-100
FRANK O LANTERMAN STATE HO POMONA CA 91766	.	.	.	.	.	.	1	0	0-100	.	.	.	3	0	0-98	1	0	0-100	.	.	.	1	0	0-100	.	.	.
FRANK R HOWARD MEM HOSP WILLITS CA 95490	2	50	3-92	.	.	.	4	0	0-75	.	.	.	36	6	1-20	5	20	0-71	3	0	0-100	16	13	0-34	15	0	0-36
FREMONT MEDICAL CENTER YUBA CITY CA 95991	11	18	7-60	9	33	11-68	40	15	3-23	.	.	.	112	6	2-12	59	8	1-16	25	0	0-96	67	6	1-13	84	1	0-9
FRENCH HOSP LOS ANGELES CA 90012	17	18	9-54	8	50	22-82	7	0	1-58	1	0	0-100	57	4	2-17	17	0	1-34	3	0	0-100	112	1	2-11	27	0	0-23
FRENCH HOSP SAN FRANCISCO CA 94118	8	13	5-63	17	35	18-63	46	4	3-21	17	0	0-89	94	5	2-12	47	4	1-18	11	0	0-99	72	1	2-13	100	1	0-8
FRENCH HOSP SAN LUIS OBISPO CA 93401	6	33	3-67	1	0	3-99	20	5	3-34	29	0	0-67	54	0	1-15	33	3	0-23	8	0	0-92	150	5	2-10	63	2	0-11
FRESNO COMM HOSP FRESNO CA 93721	64	33	12-42	73	29	27-54	149	9	5-16	81	0	0-14	395	6	3-9	228	3	2-11	51	0	0-37	487	5	3-8	168	3	1-7
FULLERTON COMM HOSP FULLERTON CA 92632	.	.	.	.	.	.	6	17	1-62	.	.	.	11	0	1-44	5	0	1-67	2	0	0-100	12	8	1-41	8	0	0-99 8
GARFIELD MEDICAL CENTER MONTEREY PARK CA 91754	11	9	7-59	11	27	14-68	20	5	3-33	1	0	0-100	72	10	2-15	39	3	1-20	3	0	0-99	140	6	2-10	22	9	0-30

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		High Risk Diagnostic Categories																							
		Overall			Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
Name/Location	Comment/Reference																								
GENERAL HOSP EUREKA CA 95501	CA-169*	396	10	6-15	38	13	11-39	9	11	8-62	9	22	2-53	16	25	7-46	8	63	12-71	3	0	1-81	28	18	9-41
GEORGE L MEE MEM HOSP KING CITY CA 93930	CA-170*	169	12	7-19	2	0	0-90	5	80	7-76	6	33	1-63	17	0	7-46	10	40	16-70	1	100	1-98	12	0	6-52
GLENDALE ADVENTIST MED CTR GLENDALE CA 91206	CA-171	3378	12	8-14	208	29	17-33	104	36	21-40	71	25	8-28	121	24	16-32	81	36	28-51	56	18	10-34	307	27	17-29
GLENDALE MEMORIAL HOSP AND GLENDALE CA 91204	CA-172	2390	14	10-17	231	27	18-34	75	37	22-44	38	21	8-35	144	28	19-34	73	38	31-55	33	21	9-40	231	25	17-31
GOLETA VALLEY COMM HDSP SANTA BARBARA CA 93111	CA-173	622	13	8-16	52	23	11-36	33	18	13-43	17	12	6-45	43	26	12-38	33	36	24-57	14	14	6-50	34	21	8-35
GOOD SAMARITAN HDSPITAL OF SAN JOSE CA 95124	CA-174	2445	10	8-14	193	19	13-29	93	22	20-39	52	31	9-32	115	27	15-31	91	33	29-51	41	15	8-35	122	19	11-27
GRANADA HILLS COMM HDSP GRANADA HILLS CA 91344	CA-175	901	13	8-15	59	37	13-38	35	46	15-45	16	25	7-47	46	22	14-39	31	32	21-54	21	19	6-41	85	20	12-31
GREATER BAKERSFIELD MEM HO BAKERSFIELD CA 93301	CA-176*	1593	15	10-16	133	24	15-33	60	33	17-40	30	23	8-38	61	36	13-34	36	47	24-56	60	17	10-34	188	28	15-29
GREATER EL MONTE COMM HDSP SOUTH EL MONTE CA 91733	CA-177*	581	21	11-19	22	32	11-48	34	53	15-45	14	29	4-46	46	26	12-36	31	58	22-56	19	16	5-43	82	30	14-33
GROSSMONT DISTRICT HOSPITAL LA MESA CA 92041	CA-178	3901	14	10-16	344	33	18-33	142	32	21-37	80	19	9-29	197	22	17-31	148	41	31-49	118	25	10-29	397	26	15-26
HANFORD COMM HDSP HANFORD CA 93230	CA-179	715	13	9-17	38	13	13-43	23	35	14-51	18	17	4-39	41	29	14-40	31	35	25-59	33	9	5-33	74	22	12-32
HARBOR VIEW MEDICAL CTR SAN DIEGO CA 92101	CA-180	430	6	6-14	18	17	9-49	8	13	8-65	6	50	5-69	13	31	8-54	9	33	17-74	16	6	3-42	43	14	8-32
HAROLD O CHOPE COMM HOSP SAN MATEO CA 94403	CA-181*	420	11	6-14	21	33	11-49	15	27	11-55	10	30	3-52	18	6	7-44	11	55	15-68	9	22	3-54	26	12	8-39
HAWTHORNE COMM HDSP HAWTHORNE CA 90250	CA-182*	1188	14	9-16	70	27	14-37	41	37	18-46	26	19	7-39	59	14	13-35	47	53	26-54	49	16	7-32	106	19	11-28
HAWTHORNE HOSPITAL HAWTHORNE CA 90250	CA-183*	266	14	8-18	20	20	9-47	6	33	5-68	10	10	1-49	13	15	7-52	8	13	11-70	12	42	5-52	31	6	9-38
HAYWARD VESPER HDSPITAL HAYWARD CA 94541	CA-184	447	12	7-15	22	32	9-45	16	6	9-50	10	0	2-51	32	31	10-39	13	31	18-68	11	18	4-52	42	24	8-32
HAZEL HAWKINS MEMORIAL HDS HOLLISSER CA 95023	CA-185*	315	14	9-18	23	30	10-45	22	45	13-50	11	18	3-48	15	0	7-48	12	42	17-68	5	0	1-69	29	10	8-38
HEALDSBURG GEN HOSP HEALDSBURG CA 95448	CA-186*	573	11	9-18	29	28	10-42	26	35	16-51	26	19	8-41	24	29	10-43	16	19	16-61	28	29	11-45	64	9	12-33
HEMET VALLEY HOSPITAL DIST HEMET CA 92343	CA-187	4794	14	10-16	352	28	17-31	157	41	21-37	102	15	9-27	209	24	17-29	233	48	33-48	151	24	14-33	424	25	15-26
HENRY MAYO NEWHALL MEMDRIA VALENCIA CA 91355	CA-188	972	11	8-15	61	31	15-39	36	31	14-43	24	0	4-35	56	18	12-34	32	50	22-55	30	13	7-38	75	8	11-31
HERRICK MEM HOSP BERKELEY CA 94704	CA-189	1314	11	9-16	84	13	16-37	102	24	20-39	32	13	4-31	68	15	13-34	37	57	26-57	33	15	9-39	89	27	13-32
HI-DESERT MEDICAL CENTER JOSHUA TREE CA 92252	CA-190	1046	15	10-17	48	29	10-36	53	34	17-42	27	19	7-38	87	20	14-32	39	59	27-58	31	19	11-43	153	22	12-26
HIGHLAND GEN HOSP DAKLAND CA 94602	CA-191*	562	14	7-15	22	32	13-51	24	33	11-46	14	14	3-44	37	22	11-37	22	82	21-60	17	12	4-42	41	24	9-34
HILLSIDE HDSPITAL SAN DIEGO CA 92104	CA-192*	930	14	8-15	50	34	12-40	23	30	12-47	13	23	5-49	73	23	14-34	23	43	22-61	35	14	8-36	88	25	11-29
HOAG MEMORIAL HOSP PRESBYT NEWPORT BEACH CA 92663	CA-193*	3043	11	10-16	316	19	20-35	110	19	20-38	57	25	14-38	153	20	16-31	78	36	26-49	37	30	12-43	227	16	15-29
HOLLYWOOD COMMUNITY HDSPIT HOLLYWOOD CA 90028	CA-194*	464	15	10-19	28	29	14-49	13	38	9-55	17	24	7-46	14	21	8-52	10	40	16-71	14	7	5-48	49	35	14-39

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

CA-12

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
GENERAL HOSP EUREKA CA 95501	3	33	1-82	4	0	5-80	9	11	1-50	6	0	0-100	24	0	0-25	47	6	1-18	8	0	0-100	21	24	1-28	31	0	0-23
GEORGE L MEE MEM HOSP KING CITY CA 93930	1	0	0-100	1	100	1-97	8	25	2-55	.	.	.	17	0	1-32	6	0	0-97	3	0	0-100	21	0	1-27	4	0	0-96
GLENOALE ADVENTIST MED CTR GLENDALE CA 91206	28	18	8-46	40	48	23-56	72	6	3-18	24	0	0-84	212	3	3-10	165	8	2-12	26	4	0-66	317	4	2-7	171	1	0-6
GLENOALE MEMORIAL HOSP AND GLENDALE CA 91204	15	27	8-55	17	41	19-65	68	10	5-22	25	0	0-55	186	10	3-11	140	8	2-13	22	0	0-90	289	4	3-9	154	1	0-6
GOLETA VALLEY COMM HOSP SANTA BARBARA CA 93111	5	20	4-74	2	50	2-90	28	7	1-25	3	0	0-100	37	5	1-18	32	0	0-23	16	0	0-95	73	7	1-12	42	0	0-18
GOOD SAMARITAN HOSPITAL OF SAN JOSE CA 95124	16	19	5-50	16	44	19-66	74	1	3-17	22	0	0-81	192	4	2-9	65	0	0-15	29	0	0-79	333	6	3-8	130	2	0-7
GRANADA HILLS COMM HOSP GRANADA HILLS CA 91344	11	55	5-56	4	0	6-81	17	6	1-34	.	.	.	70	4	2-14	73	3	1-14	13	0	0-100	112	6	2-11	56	0	0-12
GREATER BAKERSFIELD MEM HO BAKERSFIELD CA 93301	14	36	11-60	38	45	26-59	72	10	4-19	.	.	.	145	8	3-12	76	9	2-16	24	0	0-90	127	1	2-11	161	1	0-6
GREATER EL MONTE COMM HOSP SOUTH EL MONTE CA 91733	9	33	3-59	13	46	16-66	31	10	3-26	.	.	.	39	3	1-19	20	0	0-30	2	0	0-100	57	7	1-15	16	6	0-54
GROSSMONT DISTRICT HOSPITAL LA MESA CA 92041	34	15	8-43	49	43	22-52	117	8	5-17	6	0	0-100	317	8	3-10	158	3	2-11	40	3	0-30	330	6	3-8	241	4	0-5
HANFORD COMM HOSP HANFORD CA 93230	12	50	10-62	11	36	13-66	21	5	2-31	1	0	0-100	64	5	2-16	55	4	1-16	17	0	0-96	47	4	2-17	29	0	0-30
HARBOR VIEW MEDICAL CTR SAN DIEGO CA 92101	3	33	4-85	1	0	1-97	5	0	0-69	2	0	0-100	24	0	0-25	35	6	1-21	1	0	0-100	22	0	1-26	21	0	0-53
HAROLD O CHOPE COMM HOSP SAN MATEO CA 94403	7	14	2-63	1	100	1-97	13	0	1-40	.	.	.	23	9	1-26	11	18	0-55	3	0	0-100	9	11	0-50	20	5	0-60
HAWTHORNE COMM HOSP HAWTHORNE CA 90250	11	45	9-63	14	36	19-68	30	0	3-27	1	0	0-100	90	7	3-14	71	10	2-16	2	0	0-100	86	13	3-14	67	4	0-11
HAWTHORNE HOSPITAL HAWTHORNE CA 90250	4	0	3-77	3	67	9-91	2	0	0-89	3	0	0-100	32	13	1-21	11	18	1-45	1	0	0-100	17	0	1-33	17	0	0-59
HAYWARD VESPER HOSPITAL HAYWARD CA 94541	8	25	8-68	4	50	2-75	17	18	2-35	.	.	.	31	0	1-21	11	9	0-45	2	0	0-100	42	5	1-17	60	2	0-12
HAZEL HAWKINS MEMORIAL HOS HOLLISTER CA 95023	.	.	.	8	25	9-68	10	10	1-47	.	.	.	37	8	1-19	14	0	0-39	2	0	0-100	32	0	1-20	13	8	0-51
HEALOSBURG GEN HOSP HEALOSBURG CA 95448	.	.	.	10	20	14-69	25	4	3-30	2	0	0-100	61	5	2-15	15	13	0-37	8	0	0-100	46	4	2-18	36	0	0-21
HEMET VALLEY HOSPITAL OIST HEMET CA 92343	39	13	14-50	59	34	25-53	145	10	4-15	12	0	0-100	469	7	4-9	271	3	1-10	61	2	0-32	560	4	3-7	328	2	1-4
HENRY MAYO NEWHALL MEMORIA VALENCIA CA 91355	7	29	10-74	7	57	14-77	25	8	1-26	1	0	0-100	106	8	2-12	35	3	0-21	12	0	0-85	99	9	2-11	62	5	0-12
HERRICK MEM HOSP BERKELEY CA 94704	19	11	6-49	3	33	9-90	20	15	2-32	2	0	0-100	81	9	2-13	85	2	1-14	4	0	0-100	62	2	1-14	48	4	0-14
HI-DESERT MEDICAL CENTER JOSHUA TREE CA 92252	2	0	0-90	9	44	14-72	39	8	4-26	.	.	.	98	9	2-12	52	0	2-18	5	0	0-100	111	5	2-11	50	6	0-14
HIGHLAND GEN HOSP OAKLAND CA 94602	4	0	3-77	3	67	2-83	13	23	1-40	2	0	0-99	35	9	1-20	18	17	1-32	1	0	0-100	19	5	0-30	18	6	0-41
HILLSIDE HOSPITAL SAN DIEGO CA 92104	5	20	4-73	7	57	10-73	35	11	3-25	1	0	0-100	89	4	2-13	36	11	1-22	2	0	0-100	60	8	1-14	74	1	0-10
HOAG MEMORIAL HOSP PRESBYT NEWPORT BEACH CA 92663	15	13	5-51	18	39	18-62	104	7	5-19	47	0	0-33	293	5	3-10	147	4	1-11	55	0	0-54	188	5	3-10	248	1	1-5
HOLLYWOOD COMMUNITY HOSPIT HOLLYWOOD CA 90028	9	56	10-68	1	0	1-97	13	8	1-41	2	0	0-100	48	8	2-18	26	4	2-27	7	0	0-58	21	5	1-28	16	6	0-50

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		High Risk Diagnostic Categories																							
		Overall			Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
Name/Location	Comment/Reference																								
HOLLYWOOD PRESBYTERIAN MEO LOS ANGELES CA 90028	CA-195	1894	15	10-17	112	28	18-38	74	47	19-40	42	19	8-34	103	17	16-34	88	56	30-52	53	15	11-36	138	23	15-31
HOLLYWOOD WEST HOSP LOS ANGELES CA 90036	CA-196*	224	26	11-23	15	60	16-63	3	0	3-83	2	100	4-92	7	43	5-64	6	33	14-80	8	63	5-62	46	39	12-36
HOLY CROSS HOSP MISSION HILLS CA 91345	CA-197*	1369	14	10-17	112	36	17-36	48	19	18-44	33	30	9-38	80	9	15-34	39	31	22-52	48	17	7-32	125	18	14-30
HOSPITAL OF THE GOOD SAMAR LOS ANGELES CA 90017	CA-198	3364	10	10-16	271	23	20-36	99	30	21-40	81	12	11-31	185	20	18-31	119	32	31-50	61	21	12-36	235	17	16-29
HUMANA HOSP WEST ANAHEIM ANAHEIM CA 92804	CA-199	1015	16	10-17	53	28	16-42	44	39	17-45	24	13	5-37	59	39	15-37	31	74	23-58	36	19	11-40	122	29	14-30
HUMANA HOSPITAL HUNTINGTON HUNTINGTON BEACH CA 92647	CA-200	799	14	9-17	57	25	13-37	50	26	18-43	32	13	6-33	53	23	11-33	42	48	24-54	24	13	4-35	68	25	12-33
HUMANA HOSPITAL SAN LEANDR SAN LEANORO CA 94578	CA-201	1537	12	9-16	142	20	15-32	68	19	17-38	44	16	8-33	85	20	17-36	48	33	25-53	37	11	7-35	129	18	11-27
HUMANA HOSPITAL WEST HILLS CANOGA PARK CA 91307	CA-202*	1295	11	9-16	96	25	15-35	36	19	16-46	32	13	8-37	76	28	15-35	53	28	27-54	36	22	9-38	107	20	13-31
HUMANA HOSPITAL WESTMINIST WESTMINISTER,CA 92683	CA-203	1041	18	9-16	56	25	14-39	56	43	18-42	26	27	7-39	57	32	13-35	52	38	26-53	29	28	4-34	99	28	11-28
HUNTINGTON MEM HOSP PASADENA CA 91105	CA-204*	4343	10	8-15	410	25	17-31	131	20	21-37	69	23	10-31	163	20	17-31	159	29	29-46	77	16	9-31	312	21	15-27
INDIAN VALLEY DISTRICT HOS GREENVILLE CA 95947	CA-205	48	6	5-26				1	0	0-97				6	17	2-63	7	29	10-71	1	0	0-98	6	0	1-62
INGLEWOOD WOMEN'S HOSPITAL LOS ANGELES CA 90056	CA-206*	82	6	4-18	9	11	3-55	3	0	6-87				2	0	1-89				5	0	1-69	7	29	2-60
INLAND VALLEY REGIONAL MEO WINDOMAR 92395	CA-207	900	11	7-15	30	17	11-43	28	11	13-46	25	8	4-34	47	26	12-36	28	43	21-56	42	17	6-32	103	13	9-25
INTER-COMMUNITY HOSP COVINA CA 91723	CA-208	1964	12	8-15	155	30	17-34	75	25	16-37	43	14	7-32	89	19	16-34	74	38	26-50	41	24	8-35	154	27	14-29
JOHN C FREMONT HOSPITAL MARIPOSA CA 95338	CA-209*	122	16	8-22	4	50	2-75	6	0	5-68	6	17	1-63	10	10	7-58	1	100	2-98	6	50	2-64	19	16	9-47
JOHN F KENNEDY MEMORIAL HO INDIO CA 92201	CA-210	937	13	9-16	58	24	13-37	37	27	16-46	25	32	9-42	56	14	13-36	40	45	25-55	27	26	6-38	77	26	12-31
JOHN MUIR MEM HOSP WALNUT CREEK CA 94598	CA-211	2839	12	9-15	271	24	16-31	112	34	21-39	76	11	8-27	99	25	15-32	89	47	30-52	59	19	8-31	209	26	14-27
KAISER FOUND HOSP ANAHEIM ANAHEIM CA 92807	CA-212	1122	11	9-16	117	25	14-33	34	18	13-42	15	13	4-44	52	23	14-37	56	16	24-50	18	11	7-46	116	25	14-30
KAISER FOUNDATION HOSP BELLFLOWER CA 90706	CA-213	1757	10	9-16	203	18	16-32	60	18	15-38	46	20	7-31	100	24	16-34	99	20	27-47	31	19	7-38	150	18	11-26
KAISER FOUNDATION HOSP FONTANA CA 92335	CA-214	3246	12	10-16	323	19	16-30	145	28	19-35	65	15	7-28	157	27	17-31	185	24	28-44	75	25	12-35	241	21	13-26
KAISER FOUNDATION HOSP HARBOR CITY CA 90710	CA-215	1742	12	10-17	199	21	17-34	73	26	18-40	22	14	7-42	105	18	15-32	97	30	28-49	39	15	7-35	131	20	13-29
KAISER FOUNDATION HOSP HAYWARD CA 94545	CA-216	1388	10	8-15	144	14	13-30	46	17	16-42	28	18	5-35	69	26	13-33	63	22	23-47	21	19	5-40	120	19	11-27
KAISER FOUNDATION HOSP LOS ANGELES CA 90027	CA-217	3071	10	10-16	339	22	17-32	138	15	19-35	90	17	9-28	163	17	18-32	115	29	29-49	67	19	14-38	197	16	15-29
KAISER FOUNDATION HOSP LOS ANGELES CA 90034	CA-218	1801	10	9-16	162	19	14-31	66	14	15-37	34	12	7-35	116	20	16-33	77	17	27-49	38	29	9-38	150	28	14-30
KAISER FOUNDATION HOSP MARTINEZ CA 94553	CA-219	817	12	8-15	94	19	12-32	29	14	12-44	15	20	5-45	31	32	12-42	37	22	20-50	17	24	8-49	73	26	9-28
KAISER FOUNDATION HOSP OAKLAND CA 94611	CA-220	2079	16	9-16	260	32	16-31	87	22	17-36	64	19	7-28	92	23	14-32	80	25	25-48	45	29	12-40	172	28	14-28

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

CA-14

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
HOLLYWOOD PRESBYTERIAN MED LOS ANGELES CA 90028	18	17	8-52	35	26	22-56	72	8	4-19	27	0	0-76	167	5	4-12	82	10	3-16	6	0	0-100	151	6	3-11	136	3	0-6
HOLLYWOOD WEST HOSP LOS ANGELES CA 90036	5	40	7-78	12	50	16-68	5	0	0-76	3	0	0-100	27	11	1-23	22	14	1-29	.	.	.	17	0	0-32	4	0	0-99
HOLY CROSS HOSP MISSION HILLS CA 91345	13	23	6-54	28	25	24-62	46	15	4-24	8	0	0-98	121	8	3-13	59	2	1-16	10	0	0-100	100	7	2-12	88	1	0-9
HOSPITAL OF THE GOOD SAMAR LOS ANGELES CA 90017	24	8	10-50	31	42	24-61	91	8	6-20	58	0	0-20	272	4	3-10	140	4	2-12	24	0	0-56	400	5	3-8	224	0	1-6
HUMANA HOSP WEST ANAHEIM ANAHEIM CA 92804	6	0	2-66	14	50	16-64	29	7	3-28	1	0	0-100	79	11	3-15	53	8	3-20	11	0	0-77	97	4	2-11	59	3	0-12
HUMANA HOSPITAL HUNTINGTON HUNTINGTON BEACH CA 92647	8	50	8-68	5	40	9-80	24	0	2-29	.	.	.	78	5	2-14	23	4	0-28	9	11	0-97	75	3	1-12	29	3	0-42
HUMANA HOSPITAL SAN LEANDR SAN LEANORO CA 94578	24	33	14-55	20	35	20-63	42	12	3-22	.	.	.	170	8	3-11	35	3	1-21	13	0	0-99	99	7	2-12	175	1	0-5
HUMANA HOSPITAL WEST HILLS CANOGA PARK CA 91307	13	8	4-52	7	29	16-79	48	8	4-22	7	0	0-100	120	2	2-11	47	2	1-18	14	0	0-97	117	3	2-10	115	3	0-7
HUMANA HOSPITAL WESTMINIST WESTMINISTER,CA 92683	7	0	4-65	10	50	13-68	30	20	2-24	7	0	0-100	91	9	2-12	44	7	1-18	3	33	0-100	100	8	2-11	61	2	0-13
HUNTINGTON MEM HOSP PASADENA CA 91105	43	14	10-43	35	34	21-54	147	8	4-14	64	2	0-17	341	6	3-9	176	3	2-11	61	0	0-31	544	6	3-7	366	2	1-4
INOIAN VALLEY DISTRICT HOS GREENVILLE CA 95947	.	.	.	.	.	.	.	.	.	.	.	.	4	0	0-92	.	.	.	.	.	.	9	0	0-50	.	.	.
INGLEWOOD WOMEN'S HOSPITAL LOS ANGELES CA 90056	.	.	.	2	0	3-91	.	.	.	.	.	.	14	0	0-42	4	0	0-95	.	.	.	6	17	0-81	4	0	0-100
INLAND VALLEY REGIONAL MED WINOOWAR 92395	8	38	9-70	12	50	17-69	19	32	2-32	1	0	0-100	91	7	2-12	60	5	1-15	7	0	0-100	135	4	2-10	34	3	0-26
INTER-COMMUNITY HOSP COVINA CA 91723	15	40	7-53	17	24	18-63	44	9	2-20	3	0	0-100	134	5	2-11	69	1	1-15	24	0	0-98	278	5	2-7	120	1	0-7
JOHN C. FREMONT HOSPITAL MARIPOSA CA 95338	2	0	1-90	5	60	8-79	1	0	0-100	.	.	.	8	0	0-57	2	0	0-92	.	.	.	14	7	0-37	6	17	0-89
JOHN F. KENNEDY MEMORIAL HO INDIO CA 92201	9	56	4-59	4	0	7-82	37	3	3-24	11	0	0-99	90	7	2-12	46	0	1-19	7	0	0-100	69	12	2-14	51	2	0-13
JOHN MUIR MEM HOSP WALNUT CREEK CA 94598	20	30	10-53	29	31	23-60	139	10	4-14	54	0	0-19	251	4	3-10	138	2	1-11	20	0	0-98	209	5	2-9	258	4	1-5
KAISER FOUNO HOSP ANAHEIM ANAHEIM CA 92807	15	13	8-56	12	42	14-65	31	3	3-26	8	0	0-100	88	6	2-12	62	2	1-15	8	0	0-100	116	3	2-11	65	3	0-11
KAISER FOUNDATION HOSP BELLFLOWER CA 90706	28	25	7-45	8	38	11-70	39	3	3-23	12	0	0-99	138	5	2-10	130	0	1-11	17	0	0-99	155	3	2-9	132	3	0-6
KAISER FOUNDATION HOSP FONTANA CA 92335	30	23	7-44	33	55	24-60	74	3	3-18	11	0	0-99	309	6	3-9	188	5	2-11	31	3	0-97	350	2	3-8	182	4	1-6
KAISER FOUNDATION HOSP HARBOR CITY CA 90710	12	42	10-62	20	35	16-57	45	4	2-21	7	14	0-99	163	9	3-11	90	3	1-13	15	0	0-93	164	2	2-10	99	0	0-8
KAISER FOUNDATION HOSP HAYWARD CA 94545	10	30	6-61	13	46	14-64	20	10	2-32	3	0	0-100	157	6	2-9	91	4	2-14	15	7	0-99	161	5	2-9	87	2	0-9
KAISER FOUNDATION HOSP LOS ANGELES CA 90027	21	43	10-52	26	27	17-54	83	5	5-20	67	0	0-18	213	5	3-10	179	5	1-10	42	0	0-43	385	4	3-8	157	1	0-6
KAISER FOUNDATION HOSP LOS ANGELES CA 90034	8	38	4-63	22	55	22-63	32	0	2-25	10	0	0-99	175	5	3-10	110	5	1-13	9	0	0-99	223	3	3-9	66	0	0-11
KAISER FOUNDATION HOSP MARTINEZ CA 94553	11	18	4-55	4	50	8-84	19	0	2-33	1	0	0-100	87	9	1-11	54	0	1-16	4	0	0-100	86	3	2-12	44	0	0-22
KAISER FOUNDATION HOSP OAKLAND CA 94611	24	38	8-48	17	71	15-59	76	11	3-17	41	0	0-50	186	8	3-11	141	9	2-12	22	0	0-89	153	5	2-9	138	2	0-6

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		High Risk Diagnostic Categories																							
		Overall			Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
Name/Location	Comment/Reference																								
KAISER FOUNDATION HOSP PANORAMA CITY CA 91402	CA-221	2205	10	8-15	196	23	14-31	91	13	17-36	38	18	7-33	93	20	15-33	143	20	27-45	29	34	12-45	186	17	12-26
KAISER FOUNDATION HOSP REOWOOD CITY CA 94063	CA-222	1052	10	8-15	112	29	14-33	74	14	17-38	27	15	6-37	32	41	13-43	33	30	21-54	13	15	6-51	69	13	9-28
KAISER FOUNDATION HOSP RICHMONO CA 94804	CA-223	374	17	10-19	6	50	6-70	17	41	12-54	2	100	1-89	38	24	10-36	11	18	13-65	21	48	14-54	54	22	12-36
KAISER FOUNDATION HOSP SACRAMENTO CA 95825	CA-224	2753	12	8-14	388	27	16-30	86	26	15-34	70	19	7-27	82	22	14-33	95	33	23-44	41	27	12-40	215	17	12-25
KAISER FOUNDATION HOSP SAN DIEGO CA 92120	CA-225	1953	12	8-14	238	31	14-29	63	24	16-39	74	14	9-30	64	28	14-35	55	24	24-50	39	23	14-44	122	21	12-28
KAISER FOUNDATION HOSP SAN FRANCISCO CA 94115	CA-226	1903	11	8-15	201	28	18-34	64	25	17-39	44	11	7-31	84	15	13-32	75	37	25-48	23	4	3-36	134	20	13-29
KAISER FOUNDATION HOSP SAN RAFAEL CA 94903	CA-227	1174	11	9-16	127	30	17-36	48	15	16-41	23	30	9-44	53	15	12-35	29	28	21-55	25	36	9-43	86	24	13-32
KAISER FOUNDATION HOSP SANTA CLARA CA 95051	CA-228	1449	13	10-16	189	28	16-33	41	24	13-40	46	20	8-33	60	15	12-33	92	21	26-47	34	26	10-41	116	22	11-28
KAISER FOUNDATION HOSP SOUTH SAN FRANCISCO CA 94080	CA-229	952	13	9-17	96	22	15-35	38	18	14-42	32	22	8-38	49	16	12-35	46	39	26-55	22	18	10-47	81	16	9-27
KAISER FOUNDATION HOSP VALLEJO CA 94590	CA-230	1769	12	8-15	170	22	14-31	57	21	14-37	56	20	8-30	78	27	14-33	63	40	25-49	40	13	8-35	141	28	14-30
KAISER FOUNDATION HOSP WALNUT CREEK CA 94596	CA-231	1261	13	9-16	142	30	15-32	45	31	17-43	47	13	8-32	54	24	14-38	52	37	25-52	20	30	3-38	97	14	12-30
KAISER FOUNDATION HOSP SO SACRAMENTO, CA 95823	CA-232*	605	10	8-15	62	23	12-36	25	24	13-48	12	17	3-47	25	16	8-40	34	26	21-53	11	0	4-51	32	28	7-35
KAISER FOUNDATION HOSPITAL WOOLANO HILLS CA 91367	CA-233	694	10	8-16	64	33	14-38	27	15	13-46	10	0	2-50	22	9	10-46	40	18	21-51	17	29	10-53	42	14	8-33
KAWEAH DELTA OISTRCT HOSP VISALIA CA 93277	CA-234	2304	13	10-16	185	31	20-37	82	24	19-39	66	21	11-34	121	26	18-34	45	40	24-52	63	24	8-30	203	27	16-30
KENNETH NORIS JR CANCER HO LOS ANGELES CA 90033	CA-235*	289	16	10-20	106	19	15-35	.	.	.	9	22	3-54	.	.	.	.	.	.	15	40	8-51	8	38	6-62
KERN MEDICAL CTR BAKERSFIELD CA 93305	CA-236	680	12	7-14	28	39	15-49	20	45	12-50	8	25	2-55	33	24	10-39	20	30	16-56	22	18	5-40	61	16	9-30
KERN VALLEY HOSPITAL LAKE ISABELLA CA 93240	CA-237*	417	12	10-19	23	35	10-46	15	27	9-52	10	20	2-50	33	27	11-40	20	30	19-60	14	21	11-57	70	10	11-31
KINGSBURG GEN HOSP KINGSBURG CA 93631	CA-238*	71	10	5-21	.	.	.	.	.	.	4	25	1-74	2	100	0-89	3	0	8-89	8	0	1-56	10	20	6-56
KLAMATH/TRINITY COMMUNITY HOOPA CA 95546	CA-239*	31	13	5-30	1	100	0-97	.	.	.	1	0	0-99	2	0	3-90	1	100	3-100	1	0	0-100	6	17	3-65
L A CO HARBOR-UCLA MED CTR TORRANCE CA 90509	CA-240	711	14	7-14	31	23	11-43	24	29	11-45	17	18	2-38	34	18	11-39	28	71	21-57	7	14	3-61	75	27	11-30
LA HABRA COMMUNITY HOSP LA HABRA CA 90631	CA-241*	620	12	7-14	27	30	12-47	26	54	13-48	16	6	2-39	19	11	7-44	29	45	21-56	8	13	1-56	50	30	10-33
LA PALMA HOSP MEDICAL CTR BUENA PARK CA 90620	CA-242	501	13	7-15	19	32	8-46	22	27	11-47	6	33	2-64	28	11	10-40	13	77	16-66	4	100	4-78	61	25	9-30
LAC/OLIVE VIEW MEO CTR-MIO SYLMAR, CA 91342	CA-243*	171	4	3-13	8	25	3-57	2	0	1-89	3	33	2-81	5	0	3-70	6	17	7-72	1	0	0-99	6	17	3-64
LAGUNA HONDA HOSP SAN FRANCISCO CA 94116	CA-244	119	34	16-32	.	.	.	4	50	3-76	4	25	3-77	4	50	1-74	8	38	19-79	3	0	0-82	58	38	17-41
LAKEVIEW COMM HOSP LAKEPORT CA 95453	CA-245	615	14	10-18	40	20	10-37	32	31	16-48	13	8	5-49	25	28	14-48	20	55	21-63	30	13	6-37	84	24	13-32
LAKEVIEW MEDICAL CENTER PACOIMA CA 91331	CA-246*	71	34	6-23	.	.	.	3	67	2-82	2	0	1-89	1	100	1-97	5	60	10-80	9	0	1-53	14	64	5-47

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

CA-16

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
KAISER FOUNDATION HOSP PANORAMA CITY CA 91402	19	16	10-54	17	24	18-63	46	4	2-19	31	0	0-70	242	4	2-9	104	8	1-12	18	0	0-99	209	1	2-8	159	1	0-6
KAISER FOUNDATION HOSP REOWOOD CITY CA 94063	2	50	1-90	4	50	8-84	27	11	2-27	19	0	0-94	75	4	2-14	50	2	1-17	6	0	0-100	53	6	1-15	157	1	0-6
KAISER FOUNDATION HOSP RICHMOND CA 94804	8	63	9-69	2	0	3-91	1	0	0-100				16	13	1-35	11	0	2-46				37	3	1-19	9	0	1-49
KAISER FOUNDATION HOSP SACRAMENTO CA 95825	28	14	9-47	19	32	14-56	69	3	2-16	11	0	0-100	244	7	2-8	158	3	1-11	38	0	0-95	151	5	2-9	219	1	0-5
KAISER FOUNDATION HOSP SAN DIEGO CA 92120	19	21	12-57	20	60	22-65	65	6	2-17	3	0	0-100	161	4	2-10	157	3	0-11	38	0	0-51	117	2	2-11	190	0	0-5
KAISER FOUNDATION HOSP SAN FRANCISCO CA 94115	22	32	9-50	14	50	12-60	45	4	2-20	28	0	0-65	157	8	2-10	95	4	2-14	13	0	0-100	268	3	2-7	101	1	0-8
KAISER FOUNDATION HOSP SAN RAFAEL CA 94903	6	0	5-70	11	27	11-63	32	6	3-26	6	0	0-100	112	9	2-12	64	2	1-16	16	0	0-95	73	4	2-14	103	1	0-8
KAISER FOUNDATION HOSP SANTA CLARA CA 95051	14	7	4-50	10	60	16-72	48	6	3-21	9	0	0-100	140	8	2-11	57	5	1-16	27	0	0-97	144	3	2-9	86	1	0-9
KAISER FOUNDATION HOSP SOUTH SAN FRANCISCO CA 94080	12	8	5-55	12	42	16-68	24	13	1-27	1	0	0-100	109	9	2-12	60	7	1-16	6	0	0-100	89	1	1-10	36	0	0-22
KAISER FOUNDATION HOSP VALLEJO CA 94590	17	24	7-51	28	39	21-58	44	7	2-21	2	0	0-100	140	4	2-10	93	6	1-13	26	0	0-84	133	5	2-10	97	0	0-9
KAISER FOUNDATION HOSP WALNUT CREEK CA 94596	14	21	6-53	8	13	8-67	44	7	2-20	1	0	0-100	104	5	2-12	53	6	0-19	16	0	0-99	101	5	2-12	93	1	0-9
KAISER FOUNDATION HOSP SO SACRAMENTO, CA 95823	4	0	1-76	5	60	8-79	13	0	1-40	1	0	0-100	44	11	1-17	40	0	1-19	9	0	0-100	43	0	1-16	41	2	0-17
KAISER FOUNDATION HOSPITAL WOODLAND HILLS CA 91367	5	20	4-74	7	71	16-80	13	0	0-41	2	0	0-100	67	4	1-14	31	6	0-23	7	0	0-100	89	3	2-12	46	2	0-17
KAWEAH OELTA DISTRICT HOSP VISALIA CA 93277	40	15	10-44	49	35	26-56	65	6	5-21	29	3	0-77	145	13	4-14	102	3	1-13	23	0	0-49	177	4	2-9	189	2	0-5
KENNETH NORIS JR CANCER HO LOS ANGELES CA 90033	1	0	0-97	2	100	6-94							9	0	1-49	27	0	0-31	9	0	0-88	1	0	0-100	1	0	0-99
KERN MEDICAL CTR BAKERSFIELD CA 93305	11	9	6-58	14	43	15-63	22	9	2-31	2	0	0-100	32	16	1-21	36	3	0-21	3	0	0-100	47	6	1-16	18	0	0-45
KERN VALLEY HOSPITAL LAKE ISABELLA CA 93240	8	13	5-64	2	0	2-90	2	0	0-95				43	5	1-18	9	11	1-50				73	5	2-14	9	0	0-91
KINGSBURG GEN HOSP KINGSBURG CA 93631	1	0	0-99	1	100	1-97	1	0	0-100				2	0	0-98	5	0	0-73				6	17	0-69	3	0	0-99
KLAMATH/TRINITY COMMUNITY HOOPA CA 95546				1	100	0-97							3	0	0-95	3	0	0-89							1	0	0-100
L A CO HARBOR-UCLA MEO CTR TORRANCE CA 90509	25	8	2-40	6	50	9-75	10	10	1-47	9	0	0-100	41	10	2-19	33	24	1-22	6	0	0-100	56	4	1-14	26	0	0-41
LA HABRA COMMUNITY HOSP LA HABRA CA 90631	4	50	6-82	1	0	1-97	18	6	1-33				50	12	1-16	13	0	0-43	3	0	0-100	64	2	1-13	31	3	0-24
LA PALMA HOSP MEDICAL CTR BUENA PARK CA 90620	9	44	7-64	6	17	10-76	15	7	1-37				44	7	1-16	19	5	0-31	7	0	0-100	44	0	1-15	23	4	0-49
LAC/OLIVE VIEW MEO CTR-MIO SYLMAR, CA 91342	1	100	0-97										7	14	0-69	3	0	0-99				10	0	0-47	1	0	0-100
LAGUNA HONOA HOSP SAN FRANCISCO CA 94116	2	100	7-95	4	50	8-83							3	33	1-81	7	29	0-58				4	50	0-79			
LAKEVIEW COMM HOSP LAKEPORT CA 95453	10	20	5-59	4	0	4-78	23	4	2-30				51	6	1-16	27	0	1-25	3	0	0-100	73	3	2-13	34	0	0-18
LAKEVIEW MEDICAL CENTER PACOIMA CA 91331				1	0	0-97							2	50	0-91	3	0	0-97	1	0	0-100	7	29	0-72			

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		High Risk Diagnostic Categories																									
		Overall			Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease				
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent		
Name/ Location	Comment/ Reference	LANCASTER COMM HOSP LANCASTER CA 93534	CA-247*	1528	10	8-15	86	26	14-35	27	19	15-49	39	10	8-35	84	24	13-31	31	32	20-54	30	27	8-39	193	16	14-28
LASSEN COMMUNITY HOSP SUSANVILLE CA 96130	CA-248*	252	13	7-17	5	60	7-76	7	43	10-72	5	20	4-73	9	33	5-57	3	100	7-88	11	18	3-50	38	24	9-36		
LAUREL GROVE HOSP CASTRO VALLEY CA 94546	CA-249*	285	12	7-17	18	22	11-52	9	44	12-68	7	43	2-60	17	18	9-48	5	60	11-81	12	25	3-48	25	20	7-38		
LETTERMAN GEN HOSP SAN FRANCISCO CA 94129	CA-250*	1	0	0-100																							
LINOA VISTA COMM HOSP LOS ANGELES CA 90023	CA-251*	344	11	9-18	14	14	11-57	9	33	10-66	14	7	4-46	24	25	11-45	1	0	1-97	11	0	3-50	40	25	14-42		
LINOSAY DISTRICT HOSPITAL LINOSAY CA 93247	CA-252*	363	11	8-17	14	36	6-49	8	25	7-63	13	8	3-45	32	22	10-39	12	25	16-67	14	0	2-44	39	13	9-35		
LITTLE COMPANY OF MARY HOS TORRANCE CA 90503	CA-253	1912	12	9-16	138	19	14-32	59	39	17-41	50	22	9-33	112	18	15-31	76	34	29-52	35	31	9-39	173	18	13-28		
LOOI COMM HOSP LOOI CA 95240	CA-254	460	13	9-17	19	21	10-49	18	39	13-53	12	17	3-48	33	24	10-37	19	32	16-58	14	7	4-47	45	11	11-36		
LOOI MEM HOSP LOOI CA 95240	CA-255	1300	15	9-16	112	28	14-34	59	29	16-40	38	24	9-37	64	31	13-33	47	51	27-55	37	16	9-39	97	15	11-29		
LOMA LINOA COMMUNITY HOSP LOMA LINDA CA 92354	CA-256	1049	9	8-15	51	14	9-34	34	24	19-51	24	17	5-36	41	12	12-38	25	28	26-64	34	26	6-35	108	19	14-32		
LOMA LINOA UNIVERSITY MEOI LOMA LINOA CA 92354	CA-257	3750	10	9-15	374	23	21-35	102	24	20-39	94	20	13-32	113	23	15-31	85	28	27-49	86	30	16-38	205	23	14-28		
LOMPOC DISTRICT HOSP LOMPOC CA 93436	CA-258*	556	14	8-16	47	21	13-40	22	32	14-51	22	23	6-39	27	37	12-45	15	47	22-69	7	29	4-63	40	23	8-33		
LONG BEACH COMMUNITY HOSPI LONG BEACH CA 90804	CA-259	1919	12	10-16	145	26	18-36	71	39	19-41	33	18	9-38	92	20	15-33	52	48	25-52	42	7	9-36	214	19	14-28		
LONG BEACH HOSPITAL LONG BEACH CA 90813	CA-260	289	9	8-18	11	18	10-62	9	22	8-62	8	25	3-58	17	6	9-50	1	100	1-98	13	0	4-48	44	25	12-37		
LOS ALAMITOS GENERAL HOSPI LOS ALAMITOS CA 90720	CA-261	1837	15	13-20	135	26	17-36	89	28	22-43	63	21	12-34	142	17	18-33	111	42	35-55	26	27	9-43	190	28	16-30		
LOS ALTOS HOSP LONG BEACH CA 90808	CA-262*	217	15	8-18	19	16	8-47	9	56	9-64	4	25	1-75	10	20	4-53	8	88	11-70	7	29	6-67	21	19	7-41		
LOS ANGELES COMMUNITY HOSP LOS ANGELES CA 90023	CA-263*	263	5	5-14	11	27	12-64	3	0	4-84	5	0	1-69	7	14	4-62	1	0	1-97	13	0	3-47	22	9	5-37		
LOS ANGELES COUNTY USC MEO LOS ANGELES CA 90033	CA-264	1482	9	6-13	80	36	17-40	38	21	12-39	22	14	4-37	67	10	11-31	45	36	25-54	26	15	3-34	101	13	10-26		
LOS BANOS COMM HOSP LOS BANOS CA 93635	CA-265*	303	12	9-19	12	42	6-53	16	31	10-52	13	8	6-51	17	6	7-45	14	43	19-67	7	29	3-62	41	15	10-35		
LOS MEQUANOS COMMUNITY HOSP PITTSBURG CA 94565	CA-266*	773	16	10-17	42	29	13-41	35	31	14-43	12	17	2-46	61	31	15-38	41	51	23-53	34	18	7-36	79	20	11-30		
LOS ROBLES REGIONAL MEOICA THOUSAND OAKS CA 91360	CA-267	1493	10	8-15	127	30	17-36	33	9	14-44	30	10	8-38	68	21	12-33	50	30	26-54	29	24	9-41	100	13	12-29		
LOSAANGELESOCOUNTY HIGH OE LANCASTER CA 93534	CA-268*	103	10	6-20	5	20	5-74				2	50	0-93	4	0	1-74	3	0	2-82	2	0	0-91	17	24	5-41		
MAO RIVER COMMUNITY HOSP ARCATA CA 95521	CA-269	591	16	9-17	42	26	15-44	28	29	16-49	14	36	7-50	22	36	9-43	29	48	19-53	21	24	7-44	43	33	10-36		
MAERA COMMUNITY HOSPITAL MAERA CA 93637	CA-270*	795	11	9-16	28	18	9-42	17	41	11-52	32	16	9-38	59	20	12-34	22	36	20-60	18	22	6-44	108	18	12-29		
MAMMOTH HOSPITAL MAMMOTH LAKES CA 93546	CA-271*	40	0	2-22							1	0	0-100	3	0	2-81				1	0	0-100	5	0	4-72		
MARIAN HOSP SANTA MARIA CA 93454	CA-272*	1222	15	9-16	66	24	12-35	45	24	16-43	28	14	6-35	61	28	13-35	53	49	25-52	56	25	14-39	112	29	14-32		

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

CA-18

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
LANCASTER COMM HOSP LANCASTER CA 93534	7	14	2-63	10	40	15-71	19	16	3-35	1	0	0-100	177	5	2-10	75	1	2-15	8	0	0-66	207	3	3-9	72	1	0-10
LASSEN COMMUNITY HOSP SUSANVILLE CA 96130	6	17	8-75	3	33	5-86	15	13	1-36	.	.		33	0	1-20	2	0	0-100	4	0	0-100	15	0	1-35	16	0	0-58
LAUREL GROVE HOSP CASTRO VALLEY CA 94546	2	0	1-90	.	.		1	0	0-100	5	0	0-100	31	0	1-21	12	25	3-46	7	0	0-100	9	11	0-57	13	0	0-63
LETTERMAN GEN HOSP SAN FRANCISCO CA 94129	.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.	
LINOA VISTA COMM HOSP LOS ANGELES CA 90023	4	0	1-76	6	17	13-80	6	17	2-63	1	0	0-100	36	6	1-19	37	5	1-21	2	0	0-100	26	0	1-24	16	6	0-58
LINGSAY DISTRICT HOSPITAL LINGSAY CA 93247	2	0	1-90	6	67	16-83	6	0	1-62	2	0	0-100	35	6	1-19	8	13	1-53	4	0	0-100	34	6	1-19	13	0	0-75
LITTLE COMPANY OF MARY HOS TORRANCE CA 90503	16	13	9-56	27	56	23-61	52	8	3-21	3	0	0-100	171	4	2-9	84	5	1-13	10	0	0-57	309	5	3-8	92	0	0-8
LOOI COMM HOSP LODI CA 95240	5	40	13-85	4	50	10-85	21	5	3-33	1	0	0-100	51	12	1-16	18	0	1-32	6	0	0-100	33	12	1-20	15	0	0-68
LOOI MEM HOSP LOOI CA 95240	11	45	5-57	10	30	16-72	54	4	2-19	1	0	0-100	138	11	2-11	80	6	1-14	15	0	0-95	98	7	2-11	88	1	0-9
LOMA LINDA COMMUNITY HOSP LOMA LINDA CA 92354	14	14	5-52	10	20	14-69	41	5	3-23	33	0	0-65	93	9	2-13	52	6	1-17	13	0	0-86	62	3	2-15	101	3	0-8
LOMA LINDA UNIVERSITY MED LOMA LINDA CA 92354	53	17	7-38	22	45	16-56	72	8	5-21	33	0	0-42	236	6	4-11	137	4	1-12	68	0	0-15	506	3	3-7	257	1	0-5
LOMPOC DISTRICT HOSP LOMPOC CA 93436	7	29	1-64	.	.		19	11	2-34	1	0	0-100	66	8	2-15	38	5	0-20	15	0	0-99	34	6	1-19	33	6	0-25
LONG BEACH COMMUNITY HOSP LONG BEACH CA 90804	19	21	12-56	39	36	21-54	63	10	4-20	19	0	0-96	168	2	2-10	96	3	2-14	10	0	0-69	212	5	3-9	130	0	0-6
LONG BEACH HOSPITAL LONG BEACH CA 90813	.	.		5	40	9-79	7	0	1-57	5	0	0-100	21	10	1-28	3	0	0-86	2	0	0-100	27	0	1-24	19	0	0-54
LOS ALAMITOS GENERAL HOSP LOS ALAMITOS CA 90720	32	41	16-53	33	33	24-59	64	3	5-22	1	100	0-100	158	6	4-13	81	11	4-18	18	0	0-93	175	2	3-10	90	0	0-8
LOS ALTOS HOSP LONG BEACH CA 90808	1	0	1-97	2	0	2-90	11	0	1-44	1	0	0-100	18	11	1-31	21	5	1-29	2	0	0-100	21	5	0-27	15	7	0-78
LOS ANGELES COMMUNITY HOSP LOS ANGELES CA 90023	5	40	3-72	2	0	1-89	1	0	0-100	.	.		44	5	1-18	36	0	1-21	8	0	0-97	23	0	0-25	13	8	0-51
LOS ANGELES COUNTY USC MED LOS ANGELES CA 90033	20	15	5-46	17	65	17-62	25	12	2-29	22	5	0-94	101	10	3-13	48	8	1-18	7	0	0-100	111	5	1-10	52	0	0-18
LOS BANOS COMM HOSP LOS BANOS CA 93635	1	0	0-100	.	.		1	0	0-98	.	.		33	0	1-21	16	0	0-37	3	0	0-100	37	3	2-20	2	0	0-98
LOS MEQUANS COMMUNITY HOSP PITTSBURG CA 94565	5	20	1-71	15	47	14-60	19	16	4-38	1	0	0-100	86	10	2-13	34	9	1-21	5	0	0-100	70	6	1-12	37	0	0-20
LOS ROBLES REGIONAL MEDICA THOUSAND OAKS CA 91360	14	7	4-51	12	25	15-67	42	14	3-23	3	0	0-100	160	3	2-10	58	0	0-16	24	0	0-31	213	3	2-9	99	2	0-8
LOSANGELESOCOUNTY HIGH OF LANCASTER CA 93534	3	0	3-83	4	25	6-81	1	0	0-99	.	.		5	0	0-91	5	20	1-68	.	.		6	17	0-75	2	0	0-100
MAD RIVER COMMUNITY HOSP ARCATA CA 95521	5	40	8-79	2	50	4-93	25	4	3-31	1	0	0-100	75	8	2-14	21	0	1-29	10	0	0-100	55	13	1-15	26	4	0-24
MADERA COMMUNITY HOSPITAL MADERA CA 93637	6	17	4-70	15	20	13-59	24	8	2-30	.	.		76	7	3-16	37	5	1-20	12	0	0-99	112	4	2-11	32	0	0-21
MAMMOTH HOSPITAL MAMMOTH LAKES CA 93546	1	0	0-99	.	.		2	0	0-98	.	.		1	0	0-100	.	.		.	.		14	0	0-42	2	0	0-100
MARIAN HOSP SANTA MARIA CA 93454	12	8	5-54	15	27	16-63	32	6	2-24	8	0	0-100	119	7	2-11	50	10	2-19	19	0	0-91	117	7	2-11	62	2	0-11

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		High Risk Diagnostic Categories																									
		Overall			Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease				
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent		
Name/Location	Comment/Reference	MARIN GENERAL HOSPITAL SAN RAFAEL CA 94902	CA-273	1960	13	9-15	184	17	14-30	90	22	20-40	48	19	11-37	97	29	15-32	75	48	28-52	22	23	7-42	105	24	12-30
MARK TWAIN HOSP SAN ANDREAS CA 95249	CA-274	355	14	10-19	23	17	10-46	17	59	12-53	12	33	7-54	21	19	10-47	21	38	22-63	10	10	3-53	42	12	10-35		
MARSHAL HALE MEMORIAL HOSP SAN FRANCISCO CA 94118	CA-275*	729	13	8-16	58	24	12-36	26	15	14-48	15	20	3-43	43	26	14-40	23	39	23-62	18	17	5-43	38	24	13-42		
MARSHALL HOSP PLACERVILLE CA 95667	CA-276*	1063	12	9-16	84	25	13-34	45	36	17-44	32	13	6-34	61	10	14-35	47	34	26-54	20	10	3-38	99	15	13-31		
MARTIN LUTHER HOSP MEDICAL ANAHEIM CA 92803	CA-277	869	17	11-19	81	41	17-40	15	33	10-54	28	14	6-36	35	20	12-41	32	53	25-59	14	14	5-49	142	20	15-30		
MARTIN LUTHER KING JR GEN LOS ANGELES CA 90059	CA-278	512	15	7-15	10	50	5-55	26	58	14-48	12	25	2-45	37	14	10-37	18	39	18-61	22	0	3-37	35	26	9-36		
MAYERS MEM HOSP FALL RIVER MILLS CA 96028	CA-279*	160	13	7-19	4	50	3-75	1	0	0-97	1	0	0-99	6	33	8-73	6	33	11-77	10	30	5-55	25	16	7-38		
MEDICAL CENTER OF LA MIRAO LA MIRAO CA 90638	CA-280*	394	15	9-18	21	19	10-47	18	44	11-51	14	14	5-47	31	19	11-41	22	41	18-57	2	50	3-91	38	21	10-37		
MEDICAL CENTER OF TARZANA TARZANA CA 91356	CA-281	1357	11	9-16	137	23	13-31	31	32	16-48	41	17	9-35	74	22	15-35	58	34	30-57	28	25	8-40	89	18	12-30		
MEDICAL CTR OF GARDEN GROV GARDEN GROVE CA 92643	CA-282	1004	18	11-19	68	34	15-38	41	29	16-44	27	33	9-42	74	26	15-35	48	42	26-55	47	32	10-36	156	33	16-31		
MEMORIAL HOSP AT EXETER EXETER CA 93221	CA-283	307	16	11-21	21	48	7-43	19	16	11-50	14	21	5-48	21	19	10-46	22	45	20-59	9	11	3-55	41	17	11-38		
MEMORIAL HOSP MED CTR-LONG LONG BEACH CA 90806	CA-284	5131	10	8-15	458	24	19-33	143	24	22-39	100	11	9-27	192	20	17-30	146	38	31-49	94	20	12-33	407	24	15-27		
MEMORIAL HOSP MODESTO MODESTO CA 95355	CA-285	1845	13	9-16	158	20	16-33	90	28	18-38	26	31	7-39	88	17	16-35	49	39	27-55	38	11	7-35	161	20	12-27		
MEMORIAL HOSP OF GARDENA GARDENA CA 90247	CA-286	830	16	9-16	47	23	11-36	35	31	16-46	33	24	8-37	63	32	12-33	28	46	22-57	22	0	4-38	98	22	12-30		
MEMORIAL HOSPITAL CERES CERES CA 95307	CA-287	373	12	8-16	13	38	6-50	17	35	13-55	7	43	2-59	21	5	9-44	13	38	16-65	5	0	3-71	45	22	9-33		
MEMORIAL HOSPITAL OF SAN L SAN LEANORO CA 94577	CA-288	863	20	12-20	48	29	12-38	53	30	19-45	39	26	12-41	60	23	13-34	41	46	26-56	31	32	10-42	112	25	13-30		
MENDOCINO COAST HOSPITAL FORT BRAGG CA 95437	CA-289*	416	13	8-17	18	28	6-44	23	35	13-49	12	8	3-47	22	18	12-48	17	47	18-61	15	27	5-47	48	21	8-32		
MENOCINO COMMUNITY HOSP UKIAH CA 95482	CA-290*	43	21	6-28				1	0	1-97	1	100	1-97	1	0	1-97	1	0	1-97	2	100	2-90	7	14	3-61		
MERCEO COMMUNITY MEDICAL C MERCEO CA 95340	CA-291	903	14	9-17	47	36	17-45	20	30	11-49	28	21	9-41	63	33	14-36	37	43	24-56	27	7	7-39	81	11	11-30		
MERCY GENERAL HOSPITAL SACRAMENTO CA 95819	CA-292*	3815	10	8-14	280	20	17-32	113	27	21-39	67	22	9-30	201	24	16-29	87	28	28-50	105	31	15-35	252	21	14-27		
MERCY HOSP BAKERSFIELD CA 93301	CA-293	2839	13	11-17	220	27	18-34	128	24	21-39	79	22	11-32	128	29	18-34	89	52	30-52	116	21	11-31	299	21	16-28		
MERCY HOSP MEDICAL CENTE SAN DIEGO CA 92103	CA-294	4000	10	8-15	356	19	18-33	129	21	20-37	95	8	10-29	162	25	17-31	130	38	30-49	117	11	9-28	281	20	15-27		
MERCY HOSPITAL OF FOLSOM FOLSOM CA 95630	CA-295	437	14	9-18	24	17	14-50	16	13	12-55	16	6	4-42	20	15	8-45	22	64	21-60	15	27	6-48	63	24	13-35		
MERCY MEDICAL CENTER MERCEO CA 95340	CA-296	1052	10	8-15	88	15	15-36	33	24	13-43	33	33	11-41	46	17	12-37	38	42	25-56	27	7	5-36	68	16	12-33		
MERCY MEDICAL CENTER REDDING CA 96099	CA-297*	2135	13	8-15	273	28	16-32	71	37	18-40	51	22	8-31	82	22	14-33	73	41	27-50	27	11	6-38	166	20	14-28		
MERCY SAN JUAN HOSP CARMICHAEL CA 95608	CA-298	2240	11	9-15	204	25	19-35	88	25	20-41	67	7	9-30	110	21	14-31	78	46	29-52	37	11	7-35	181	20	13-27		

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

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HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
MARIN GENERAL HOSPITAL SAN RAFAEL CA 94902	17	35	4-48	22	32	15-55	118	13	4-16	20	0	0-96	180	4	3-11	104	1	1-12	18	0	0-92	175	4	2-9	132	0	0-6
MARK TWAIN HOSP SAN ANOREAS CA 95249	3	0	3-84	5	40	8-78	19	0	1-32	1	0	0-100	25	4	1-24	7	0	0-61	.	.	.	33	0	1-19	31	0	0-32
MARSHAL HALE MEMORIAL HOSP SAN FRANCISCO CA 94118	6	17	1-66	5	60	9-79	24	13	2-30	.	.	.	69	7	2-14	54	4	1-17	4	0	0-100	36	8	1-20	71	4	0-11
MARSHALL HOSP PLACERVILLE CA 95667	18	28	7-50	7	0	9-71	44	2	2-20	1	0	0-100	91	5	1-12	54	0	1-16	20	0	0-96	67	7	2-14	59	3	0-12
MARTIN LUTHER HOSP MEDICAL ANAHEIM CA 92803	13	46	7-56	19	32	19-62	29	7	3-29	2	0	0-100	88	7	3-15	39	0	1-20	13	0	0-100	38	8	2-21	39	5	0-17
MARTIN LUTHER KING JR GEN LOS ANGELES CA 90059	6	0	2-66	10	60	13-68	11	9	1-45	1	0	0-100	18	17	0-33	9	0	0-54	.	.	.	39	3	1-17	8	0	0-98
MAYERS MEM HOSP FALL RIVER MILLS CA 96028	7	29	5-66	1	0	2-98	5	0	0-81	1	0	0-100	20	10	0-30	1	0	0-100	.	.	.	16	13	1-34	14	0	0-86
MEIOICAL CENTER OF LA MIRAO LA MIRAOA CA 90638	4	25	5-80	4	25	8-84	14	0	1-39	1	0	0-100	33	0	0-20	18	17	1-33	3	0	0-100	28	7	0-22	13	8	0-61
MEIOICAL CENTER OF TARZANA TARZANA CA 91356	12	8	6-56	12	17	19-71	26	0	2-27	7	0	0-100	121	5	2-11	70	4	1-14	30	0	0-90	115	3	2-11	60	0	0-12
MEIOICAL CTR OF GARDEN GROV GARDEN GROVE CA 92643	6	0	3-68	11	27	15-68	39	5	3-24	1	0	0-100	64	8	1-14	56	4	2-18	7	0	0-100	78	5	2-13	49	0	0-16
MEMORIAL HOSP AT EXETER EXETER CA 93221	5	20	8-79	3	33	4-84	7	0	0-59	.	.	.	40	8	1-19	11	0	0-46	5	0	0-100	23	0	1-27	5	0	0-99
MEMORIAL HOSP MEO CTR-LONG LONG BEACH CA 90806	28	29	10-48	58	40	26-54	135	8	4-16	62	2	0-16	302	5	3-9	200	4	2-11	79	0	0-25	572	4	3-7	419	2	0-4
MEMORIAL HOSP MODESTO MODESTO CA 95355	37	32	12-47	18	39	18-62	69	13	4-20	10	0	0-100	154	7	3-11	71	6	1-14	21	0	0-68	126	10	2-11	153	1	0-6
MEMORIAL HOSP OF GARDENA GAROENA CA 90247	10	30	5-59	10	50	14-69	30	13	2-26	14	0	0-87	75	8	1-12	64	9	1-15	5	20	0-100	47	11	1-17	30	0	0-24
MEMORIAL HOSPITAL CERES CERES CA 95307	4	25	3-78	2	0	4-92	12	17	2-43	.	.	.	23	4	1-28	11	0	0-48	3	0	0-100	23	4	1-26	21	5	0-36
MEMORIAL HOSPITAL OF SAN L SAN LEANORO CA 94577	11	36	12-67	26	69	26-65	28	11	3-28	2	0	0-100	69	12	2-15	53	4	2-18	2	0	0-100	70	3	2-14	26	12	0-28
MENDOCINO COAST HOSPITAL FORT BRAGG CA 95437	4	0	1-76	3	0	3-84	14	0	1-38	.	.	.	35	0	1-20	16	0	0-36	6	0	0-100	26	4	2-25	33	6	0-27
MENDOCINO COMMUNITY HOSP UKIAH CA 95482	1	100	0-97	.	.	.	.	.	.	.	.	.	4	0	0-77	1	0	0-100	.	.	.	3	0	0-93	1	0	0-100
MERCED COMMUNITY MEIOICAL C MERCED CA 95340	16	31	8-54	2	100	5-94	22	5	4-35	3	0	0-100	91	12	2-13	29	7	1-24	2	0	0-100	90	4	2-12	24	0	0-31
MERCY GENERAL HOSPITAL SACRAMENTO CA 95819	16	13	8-53	31	39	22-58	101	4	4-17	106	1	0-9	234	7	4-11	135	2	1-11	32	0	0-82	702	4	4-8	335	1	0-4
MERCY HOSP BAKERSFIELDO CA 93301	50	28	12-44	42	24	24-56	101	8	6-20	28	0	0-73	275	7	4-11	139	4	2-12	11	0	0-95	247	3	3-8	190	1	0-5
MERCY HOSP MEIOICAL CENTE SAN DIEGO CA 92103	24	29	8-48	21	48	22-63	120	8	5-17	90	0	0-9	306	3	2-8	242	2	1-10	43	0	0-50	369	6	3-8	369	2	1-4
MERCY HOSPITAL OF FOLSOM FOLSOM CA 95630	5	20	3-72	.	.	.	11	18	1-45	1	0	0-100	48	10	2-17	21	5	0-30	4	0	0-100	41	0	1-17	12	0	0-94
MERCY MEDICAL CENTER MERCED CA 95340	12	0	3-53	4	25	7-82	38	8	2-23	3	0	0-100	101	4	2-12	95	2	1-13	22	0	0-75	85	8	2-13	55	0	0-13
MERCY MEIOICAL CENTER REDDING CA 96099	25	24	7-45	4	25	4-79	63	5	3-18	19	0	0-97	205	3	2-10	105	1	0-13	36	0	0-43	134	7	2-9	224	3	0-5
MERCY SAN JUAN HOSP CARMICHAEL CA 95608	16	25	5-49	11	36	15-68	71	11	3-18	22	0	0-94	212	3	2-9	93	2	0-13	32	0	0-82	116	6	2-11	158	1	0-6

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		High Risk Diagnostic Categories																							
		Overall			Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
Name/Location	Comment/Reference																								
MERRITHEW MEMORIAL HOSP MARTINEZ CA 94553	CA-299	657	10	6-14	28	21	9-42	19	16	12-51	20	20	6-41	29	3	10-40	10	60	13-67	24	17	4-36	53	25	11-34
METHOIST HOSP OF SOUTHERN ARCAOIA CA 91006	CA-300	3146	11	8-14	300	24	16-31	121	27	20-37	81	19	8-27	126	25	15-31	101	43	27-48	44	14	7-33	217	22	14-27
METHOIST HOSPITAL SACRAMENTO CA 95823	CA-301*	1279	15	10-17	89	35	16-38	69	36	18-40	21	19	3-36	77	23	14-34	57	32	28-55	29	24	5-35	155	25	14-29
MIDWAY HOSP MEDICAL CENTER LOS ANGELES CA 90019	CA-302	1471	10	9-16	64	19	15-38	54	24	19-44	48	2	7-31	80	16	16-35	30	40	27-62	52	21	9-34	128	21	17-34
MIDWOOD COMMUNITY HOSPITAL STANTON CA 90680	CA-303	620	14	8-16	32	16	8-38	21	43	14-52	15	40	5-46	26	27	11-43	13	69	19-68	14	D	3-44	53	34	13-37
MISSION COMMUNITY HOSPITAL MISSION VIEJO CA 92691	CA-304*	1029	11	10-17	99	25	13-33	60	35	19-43	18	0	4-40	44	9	14-40	38	26	27-59	24	13	7-41	89	19	12-30
MISSION HOSPITAL HUNTINGTON PARK CA 90255	CA-305*	224	6	6-16	6	0	3-66	1	0	0-97	2	D	0-90	19	16	12-52	3	33	6-87	6	17	1-64	30	3	6-35
MISSION OAKS HOSPITAL LOS GATOS CA 95030	CA-306*	336	14	8-17	11	18	6-55	13	23	11-58	10	30	5-55	15	20	8-51	12	33	19-70	17	24	5-43	29	31	9-39
MODESTO CITY HOSP MODESTO CA 95354	CA-307*	788	12	8-15	59	17	9-32	24	38	14-50	21	14	6-41	35	29	11-39	18	39	19-62	38	13	7-35	92	26	13-31
MOORE MEO CTR ALTURAS CA 96101	CA-308*	120	13	5-18	3	33	6-87	2	100	2-89	1	0	D-97	2	0	2-90	5	60	8-78	5	20	0-70	21	19	6-39
MONO GENERAL HOSP BRIDGEPORT CA 93517	CA-309*	28	25	5-32	.	.	.	1	100	1-97	.	.	.	3	33	3-83	2	50	3-91	2	0	0-93	4	25	1-74
MONROVIA COMM HOSP MONROVIA CA 91016	CA-310*	413	14	8-16	13	23	10-57	7	29	6-66	13	23	4-47	17	24	8-48	7	14	17-80	19	32	6-44	70	24	11-31
MONTEREY PARK HOSP MONTEREY PARK CA 91754	CA-311	868	10	10-17	51	22	16-43	27	30	17-51	28	14	9-41	42	5	12-37	21	43	23-64	31	13	6-36	88	20	14-33
MONTEREY PENINSULA HOSPITA MONTEREY CA 93940	CA-312*	46	2	2-20	1	0	1-98	.	.	.	1	100	3-99	.	.	.	.	.	.	.	.	.	.	.	.
MOTION PICTURE TELEVISIO WOODLAND HILLS CA 91364	CA-313*	196	15	11-22	17	35	11-52	6	50	8-73	14	21	7-51	17	18	8-47	4	25	10-86	2	0	1-89	27	22	12-45
MOUNT ZION HOSP MEDICAL SAN FRANCISCO CA 94115	CA-314	2097	12	10-16	209	30	17-34	60	28	17-40	74	12	8-28	81	14	16-36	109	32	32-52	34	18	6-35	156	22	16-31
MOUNTAINS COMMUNITY HOSPIT LAKE ARROWHEAD CA 92352	CA-315*	50	0	2-19	.	.	.	.	.	.	1	0	0-98	5	0	1-67	.	.	.	1	0	0-97	5	0	0-69
MOUNTAIN VIEW MEDICAL CENT SIMI VALLEY CA 93065	CA-316*	322	12	8-18	20	15	13-52	11	9	8-57	5	D	1-68	16	13	10-52	12	58	16-67	9	33	4-56	43	28	9-34
MT DIABLO HOSP MEO CTR CONCORD CA 94520	CA-317	2367	11	10-16	165	19	17-34	105	26	20-39	68	12	8-29	132	20	15-31	100	30	27-48	52	13	8-32	176	20	14-28
MT SHASTA COMMUNITY HOSP MOUNT SHASTA CA 96067	CA-318*	403	12	9-18	31	32	9-39	10	30	10-62	8	25	2-55	21	10	10-47	18	6	18-60	14	36	9-55	56	27	11-34
N M HOLOERMAN HOSP YOUNTVILLE CA 94599	CA-319	375	19	11-20	12	25	7-54	9	44	8-62	14	21	4-46	32	22	14-44	25	68	21-59	4	25	1-74	54	35	11-34
N T ENLOE MEMORIAL HOSP CHICO CA 95926	CA-320	2492	12	9-15	243	30	19-35	69	22	18-40	38	8	7-33	89	36	17-36	91	44	27-48	19	5	5-42	161	16	15-30
NATIVIDAD MEDICAL CENTER SALINAS CA 93906	CA-321*	327	17	9-18	12	67	7-55	12	33	12-62	5	60	5-73	15	20	7-49	15	47	22-68	15	20	10-54	36	22	9-35
NEWHALL COMM HOSP NEWHALL CA 91321	CA-322*	18	22	2-34	3	33	1-81	1	100	0-97	.	.	.	1	100	0-97	.	.	.	.	.	.	2	50	0-91
NEWHALL COMMUNITY HOSPITAL NEWHALL, CA 91321	CA-323*	100	0	6-20	1	D	0-98	.	.	.	4	0	3-75	4	0	2-75	.	.	.	6	D	2-64	8	0	4-59
NORTH BAY HOSP VALLEJO CA 94590	CA-324*	1	0	0-99	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

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HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
MERRITHEW MEMORIAL HOSP MARTINEZ CA 94553	2	0	0-95	5	80	10-80	14	0	1-38				30	3	0-21	14	7	1-39	7	14	0-100	15	0	0-36	16	13	0-55
METHODIST HOSP OF SOUTHERN ARCAOIA CA 91006	29	21	13-52	18	44	20-64	112	4	4-16	9	0	0-100	292	7	2-8	128	3	1-11	35	0	0-74	193	7	2-9	262	3	0-4
METHOIST HOSPITAL SACRAMENTO CA 95823	11	18	5-57	8	25	13-73	38	11	3-23	1	0	0-100	140	7	3-11	51	8	2-20	10	0	0-67	108	7	2-11	77	0	0-10
MIOWAY HOSP MEDICAL CENTER LOS ANGELES CA 90019	12	17	3-53	27	33	23-61	43	9	4-24	151	0	0-6	93	5	2-13	78	4	2-15	4	0	0-100	92	3	2-13	76	0	0-10
MIOWOOD COMMUNITY HOSPITAL STANTON CA 90680	8	25	4-62	15	47	17-64	11	18	3-48	2	0	0-100	56	5	1-14	42	10	3-23	8	0	0-100	41	2	1-17	46	0	0-18
MISSION COMMUNITY HOSPITAL MISSION VIEJO CA 92691	8	13	9-70	14	43	21-71	36	11	3-25				90	4	2-12	55	4	1-16	12	0	0-67	95	4	2-12	60	0	0-12
MISSION HOSPITAL HUNTINGTON PARK CA 90255	4	25	2-76	3	33	5-86	2	0	0-98	4	0	0-100	38	3	1-18	9	22	1-50	2	0	0-100	20	5	0-28	9	0	0-87
MISSION OAKS HOSPITAL LOS GATOS CA 95030	3	67	2-83	5	20	5-74	8	13	1-53	1	0	0-100	29	3	1-23	9	11	0-53	2	0	0-100	18	11	1-31	64	0	0-13
MOOESTO CITY HOSP MOOESTO CA 95354	4	75	4-79	7	14	7-68	30	10	3-28				112	8	2-11	30	3	1-24	29	0	0-70	49	6	2-17	28	0	0-33
MODOC MED CTR ALTURAS CA 96101	1	0	0-98										13	0	0-47				3	0	0-100	20	0	0-28	5	0	0-98
MONO GENERAL HOSP BRIDGEPORT CA 93517				1	100	2-98	1	100	0-97				2	0	0-100	1	0	0-100				3	0	0-95			
MONROVIA COMM HOSP MONROVIA CA 91016	6	50	2-67	7	57	15-78	6	17	1-62				37	14	1-18	29	3	1-24	5	0	0-100	44	2	1-17	25	4	0-43
MONTEREY PARK HOSP MONTEREY PARK CA 91754	21	19	14-58	16	31	15-61	15	0	1-37				105	5	2-12	53	2	1-17	13	0	0-100	112	1	2-11	31	3	0-29
MONTEREY PENINSULA HOSPITA MONTEREY CA 93940																											
MOTION PICTURE TELEVISIO WOODLAND HILLS CA 91364	2	50	2-90	4	25	11-86	8	0	2-55	3	0	0-100	17	0	1-32	16	0	0-39				13	0	1-39	8	0	0-60
MOUNT ZION HOSP MEDICAL SAN FRANCISCO CA 94115	13	15	9-59	18	33	16-60	61	8	4-20	39	0	0-46	149	5	2-11	99	3	1-12	16	0	0-75	159	4	2-9	136	3	0-6
MOUNTAINS COMMUNITY HOSPIT LAKE ARROWHEAD CA 92352				1	0	1-97							1	0	0-100	3	0	0-100	1	0	0-100	8	0	0-69			
MOUNTAIN VIEW MEDICAL CENT SIMI VALLEY CA 93065	2	50	4-92	3	100	9-91	7	0	1-57				38	5	1-18	9	0	0-61	2	0	0-100	32	0	1-20	13	0	0-80
MT DIABLO HOSP MED CTR CONCRO CA 94520	31	16	8-44	33	39	21-56	74	11	3-18	6	0	0-100	182	6	4-12	64	2	1-15	26	0	0-91	360	4	3-8	146	1	0-6
MT SHASTA COMMUNITY HOSP MOUNT SHASTA CA 96067	3	0	12-94	2	0	3-91	18	17	1-33	1	0	0-100	56	0	2-17	23	4	0-32	4	0	0-100	28	4	1-22	31	3	0-29
N M HOLDERMAN HOSP YOUNTVILLE CA 94599				5	60	11-82	14	21	5-45				21	0	1-28	7	0	0-62				20	0	1-29	8	0	0-88
N T ENLOE MEMORIAL HOSP CHICO CA 95926	19	21	10-54	9	33	14-72	72	15	5-21	4	0	0-100	217	7	3-11	71	6	1-14	20	0	0-41	431	7	3-8	214	1	0-5
NATIVIDAD MEDICAL CENTER SALINAS CA 93906	3	0	3-84	10	40	13-69	4	25	0-79				13	23	0-39	14	7	0-38				23	9	1-26	2	0	0-100
NEWHALL COMM HOSP NEWHALL CA 91321													5	0	0-81				1	0	0-100	1	0	0-100			
NEWHALL COMMUNITY HOSPITAL NEWHALL, CA 91321				2	0	8-96							9	0	2-50	4	0	0-76	2	0	0-100	6	0	0-71	4	0	0-93
NORTH BAY HOSP VALLEJO CA 94590																			1	0	0-99						

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		High Risk Diagnostic Categories																							
		Overall			Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
Name/Location	Comment/Reference																								
NORTH COAST REHABILITATION SANTA ROSA CA 95405	CA-325*	89	0	8-23	.	.		39	0	14-42	.	.		.	.		.	.		.	.		2	0	0-90
NORTH KERN HOSP WASCO CA 93280	CA-326*	81	9	8-25	.	.		7	29	8-69	.	.		5	20	4-71	4	0	7-82	4	0	0-76	22	14	7-40
NORTHBAY MEDICAL CENTER FAIRFIELD CA 94533	CA-327	1014	14	9-16	59	24	12-36	45	31	16-43	34	15	7-34	57	12	12-34	41	51	26-56	28	29	10-43	96	22	12-30
NORTHERN INYO HOSPITAL BISHOP CA 93514	CA-328*	462	12	8-17	41	20	15-44	18	39	14-55	8	13	2-55	13	31	6-49	14	50	17-64	14	21	6-50	60	8	11-33
NORTHRIDGE HOSPITAL FOUNOA NORTHRIDGE CA 91325	CA-329	1674	10	8-14	112	29	16-36	54	28	17-41	37	11	7-33	107	23	16-32	55	33	24-50	39	15	7-35	105	19	11-28
NORWALK COMM HOSP NORWALK CA 90650	CA-330*	294	15	9-18	7	0	8-69	14	64	15-62	7	0	2-60	14	21	9-54	5	80	9-79	17	12	5-44	34	29	13-42
NOVATO COMMUNITY HOSP NOVATO CA 94947	CA-331	469	15	10-19	37	22	13-43	26	31	16-51	14	0	7-50	34	24	14-44	17	71	19-63	11	9	3-50	44	25	10-34
NU-MED REGIONAL MEDICAL CT CANOGA PARK CA 91304	CA-332*	678	15	11-18	47	36	17-45	22	32	13-49	18	22	7-45	46	28	12-37	26	38	26-63	17	12	13-56	70	27	14-35
O'CONNOR HOSPITAL SAN JOSE CA 95128	CA-333	2908	12	9-15	260	20	16-32	92	24	18-38	81	25	13-33	118	24	17-33	102	47	30-51	81	16	12-33	215	18	14-28
OAK VALLEY DISTRICT HOSP OAKDALE CA 95361	CA-334*	465	12	8-17	30	20	9-40	15	33	10-54	19	5	3-36	22	32	12-49	18	44	18-60	10	20	5-56	57	23	12-35
OAKLAND HOSP OAKLAND CA 94601	CA-335*	497	16	10-18	15	40	8-52	20	45	13-52	14	29	9-54	30	13	10-39	21	29	19-59	24	21	11-47	79	23	13-32
OJAI VALLEY COMMUNITY HOSP OJAI CA 93023	CA-336	479	16	9-18	29	31	10-42	27	37	15-49	10	30	3-52	30	20	10-40	18	56	21-64	13	31	5-50	62	19	9-30
ONTARIO COMM HOSP ONTARIO CA 91764	CA-337	476	20	9-18	6	17	6-70	15	60	10-53	15	27	5-45	28	39	9-39	25	60	22-59	15	33	7-49	65	17	11-32
OROVILLE HOSP OROVILLE CA 95965	CA-338	1098	11	9-16	103	22	13-32	42	21	16-44	32	9	8-37	39	23	10-35	43	44	29-59	22	14	6-41	124	19	12-28
ORTHOPAEDIC HOSP LOS ANGELES CA 90007	CA-339	291	1	1-10	4	25	2-74	1	0	0-97	.	.		2	50	2-90	2	0	6-94	4	0	1-74	.	.	
PACIFIC COAST HOSP SAN FRANCISCO CA 94115	CA-340*	109	1	0-30	.	.		.	.		.	.		.	.		.	.		.	.		.	.	
PACIFIC PRESBYTERIAN HOSP SAN FRANCISCO CA 94115	CA-341*	2523	8	7-14	161	21	14-31	84	24	20-40	41	12	8-34	100	16	15-33	58	26	27-53	37	11	6-34	178	15	15-30
PACIFICA COMM HOSP HUNTINGTON BEACH CA 92648	CA-342	796	16	9-17	35	34	14-44	29	28	16-49	30	17	7-37	49	33	17-43	24	67	24-62	20	20	5-41	86	26	12-31
PACIFICA HOSP OF LONG BEAC LONG BEACH CA 90806	CA-343	1095	14	9-16	63	29	15-39	20	30	13-52	26	19	7-38	57	30	14-37	24	46	23-61	22	14	3-36	118	26	13-30
PALM DRIVE HOSP SEBASTOPOL CA 95472	CA-344	846	13	8-16	61	36	11-34	33	27	17-48	16	19	6-47	54	24	13-37	26	35	22-58	21	14	6-42	84	19	13-32
PALMOALE GEN HOSP PALMOALE CA 93550	CA-345	552	10	7-15	17	24	9-50	15	20	9-52	6	33	3-66	33	15	11-39	16	50	15-59	13	8	4-48	84	12	11-29
PALO VERDE HOSP BLYTHE CA 92225	CA-346*	323	15	10-19	19	42	18-60	17	47	11-52	7	0	1-59	26	23	8-39	17	41	15-59	25	12	6-39	50	16	9-32
PALOMAR MEM HOSP ESCONOIOO CA 92025	CA-347	3292	13	9-16	363	28	17-31	148	32	20-36	81	16	7-26	189	20	17-30	120	43	28-48	89	15	7-27	258	22	13-26
PANORAMA COMMUNITY HOSP PANORAMA CITY CA 91402	CA-348	772	15	10-17	54	26	12-37	22	64	14-52	11	0	4-52	40	20	15-42	18	50	22-66	12	33	10-59	88	25	15-34
PARADISE VALLEY HOSP NATIONAL CITY CA 92050	CA-349	1298	14	8-15	71	27	14-36	35	43	16-46	18	28	5-42	85	28	15-34	38	61	27-58	51	22	8-33	100	20	14-32
PARKVIEW COMMUNITY HOSP RIVERSIDE CA 92503	CA-350	1064	15	9-17	95	17	12-31	38	50	17-47	41	12	7-32	62	32	13-34	39	38	25-56	42	24	10-37	103	25	13-30

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

CA-24

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
NORTH COAST REHABILITATION SANTA ROSA CA 95405	.	.	.	.	.	.	1	0	0-99	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
NORTH KERN HOSP WASCO CA 93280	.	.	.	3	33	5-85	.	.	.	.	.	.	2	0	0-99	2	0	0-93	.	.	.	12	0	0-43	1	0	0-100
NORTHBAY MEDICAL CENTER FAIRFIELD CA 94533	6	17	5-70	9	78	17-75	37	0	2-22	1	0	0-100	88	3	2-13	52	12	3-21	13	0	0-100	86	9	2-12	71	3	0-10
NORTHERN INYO HOSPITAL BISHOP CA 93514	3	33	3-84	1	100	1-97	21	5	1-29	.	.	.	59	7	1-15	23	4	0-28	3	0	0-100	26	12	1-25	30	0	0-26
NORTHRIDGE HOSPITAL FOUNOA NORTHRIDGE CA 91325	7	0	2-63	9	44	16-74	56	7	3-20	11	0	0-97	119	5	2-12	64	6	2-17	12	0	0-98	168	7	2-9	104	1	0-8
NORWALK COMM HOSP NORWALK CA 90650	5	40	5-75	3	67	7-89	5	40	1-67	1	0	0-100	32	13	1-21	17	12	2-35	2	0	0-98	25	0	1-24	17	0	0-71
NOVATO COMMUNITY HOSP NOVATO CA 94947	5	0	5-75	12	42	14-65	18	17	1-33	.	.	.	41	15	2-19	12	0	0-47	3	33	0-100	45	2	1-16	21	0	0-28
NU-MEO REGIONAL MEDICAL CT CANOGA PARK CA 91304	4	0	4-79	11	36	12-65	23	4	1-28	5	0	0-100	70	7	3-16	40	5	2-22	6	17	1-62	68	7	2-13	24	4	0-28
O'CONNOR HOSPITAL SAN JOSE CA 95128	28	29	11-49	23	9	18-57	87	15	5-19	58	0	0-35	251	4	3-9	122	4	1-12	32	0	0-47	382	3	3-8	205	1	0-5
OAK VALLEY DISTRICT HOSP OAKDALE CA 95361	4	25	2-76	6	33	9-76	18	0	1-33	1	0	0-100	70	6	2-14	34	3	1-21	4	0	0-100	38	0	1-17	20	0	0-46
OAKLAND HOSP OAKLAND CA 94601	4	25	1-77	9	22	11-68	23	9	2-29	.	.	.	36	8	1-19	40	15	2-21	.	.	.	34	6	1-19	20	0	0-30
OJAI VALLEY COMMUNITY HOSP OJAI CA 93023	2	100	2-91	5	60	9-79	19	5	2-34	.	.	.	42	12	2-21	21	14	2-32	6	0	0-100	38	0	1-19	18	0	0-37
ONTARIO COMM HOSP ONTARIO CA 91764	9	22	10-68	17	59	14-58	13	15	2-41	.	.	.	29	17	1-22	28	4	2-26	3	0	0-100	64	3	1-13	16	0	0-68
OROVILLE HOSP OROVILLE CA 95965	5	0	1-71	12	17	11-62	36	17	3-25	1	0	0-100	90	8	2-12	85	2	1-13	28	0	0-95	116	4	2-11	49	0	0-14
ORTHOPAEOIC HOSP LOS ANGELES CA 90007	1	0	0-99	.	.	.	10	0	0-48	.	.	.	4	0	0-97	1	0	0-100	.	.	.	1	0	0-100	164	1	0-6
PACIFIC COAST HOSP SAN FRANCISCO CA 94115	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	90	0	0-12
PACIFIC PRESBYTERIAN HOSP SAN FRANCISCO CA 94115	91	5	2-32	17	41	21-66	53	6	3-20	120	2	0-9	121	6	3-12	81	4	2-15	14	0	0-89	284	6	3-8	220	1	0-5
PACIFICA COMM HOSP HUNTINGTON BEACH CA 92648	10	40	5-58	8	50	14-74	24	4	2-30	3	0	0-100	63	3	1-13	41	2	1-19	9	11	0-100	61	2	2-16	81	4	0-9
PACIFICA HOSP OF LONG BEAC LONG BEACH CA 90806	12	8	3-52	27	41	20-57	38	3	3-24	51	0	0-31	88	5	3-14	76	12	1-14	7	0	0-74	84	8	2-12	76	0	0-10
PALM DRIVE HOSP SEBASTOPOL CA 95472	12	17	2-51	6	17	12-79	31	6	3-26	18	0	0-92	89	8	2-13	35	6	0-21	5	0	0-99	57	4	1-15	77	1	0-10
PALMOALE GEN HOSP PALMOALE CA 93550	2	0	0-97	5	20	5-73	18	11	1-32	.	.	.	54	0	1-14	16	25	1-35	3	0	0-100	68	3	2-14	15	0	0-70
PALO VERDE HOSP BLYTHE CA 92225	5	20	3-73	.	.	.	3	0	0-82	.	.	.	28	0	1-22	7	0	0-59	1	0	0-100	30	0	1-21	9	0	0-86
PALOMAR MEM HOSP ESCONDIDO CA 92025	22	50	11-53	51	31	25-54	117	6	4-15	5	0	0-100	297	6	3-10	153	2	1-11	39	0	0-66	237	5	2-8	244	1	0-5
PANORAMA COMMUNITY HOSP PANORAMA CITY CA 91402	23	43	15-57	7	43	9-72	18	17	4-38	3	0	0-100	70	7	3-16	114	6	1-12	10	0	0-98	69	9	2-15	35	0	0-29
PARADISE VALLEY HOSP NATIONAL CITY CA 92050	17	18	7-52	3	67	4-84	29	3	2-25	1	0	0-100	103	9	2-12	70	9	2-17	8	0	0-94	85	2	2-12	56	2	0-12
PARKVIEW COMMUNITY HOSP RIVERSIDE CA 92503	10	40	3-56	19	26	17-59	34	12	2-24	1	0	0-100	94	4	2-12	48	4	1-17	13	0	0-100	109	6	2-11	36	0	0-26

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		High Risk Diagnostic Categories																							
		Overall			Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
Name/Location	Comment/Reference																								
PENINSULA HOSP MEDICAL C BURLINGAME CA 94010	CA-351	2185	12	8-14	205	27	14-30	96	27	18-37	44	11	6-30	117	19	15-32	78	28	28-51	27	11	8-40	121	28	12-28
PERALTA HOSP OAKLAND CA 94609	CA-352*	1335	10	8-15	162	19	16-33	43	33	18-45	51	18	9-33	52	21	12-34	21	10	23-64	22	14	6-40	87	22	12-31
PETALUMA VALLEY HOSPITAL PETALUMA CA 94952	CA-353*	936	12	9-17	67	21	13-36	45	24	19-46	34	18	6-33	57	23	13-35	29	52	26-61	23	30	6-39	93	12	12-30
PHS INDIAN HEALTH SERVICE WINTERHAVEN CA 92283	CA-354*	15	27	5-44	.	.	.	2	50	2-90	.	.	.	.	.	.	1	100	2-98	1	100	0-100	1	0	0-99
PICO RIVERA COMM HOSP PICO RIVERA CA 90660	CA-355*	428	23	12-22	12	50	12-61	20	30	18-59	19	32	5-41	32	28	14-45	20	80	26-68	18	17	6-44	65	38	17-40
PINECREST HOSP SANTA BARBARA CA 93105	CA-356*	25	0	2-28	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	1	0	0-97	.	.	.
PIONEER HOSPITAL ARTESIA CA 90701	CA-357	542	15	8-16	28	7	6-37	20	30	11-49	13	23	3-45	38	16	10-36	31	48	24-58	14	43	4-46	67	16	7-26
PIONEERS MEMORIAL HOSPITAL BRAWLEY CA 92227	CA-358*	592	15	10-18	27	48	13-47	30	40	16-48	13	8	5-48	32	22	12-42	22	64	23-62	26	8	5-36	82	20	12-31
PLACENTIA-LINDA COMM HOSP PLACENTIA CA 92670	CA-359	627	12	8-16	49	24	12-38	17	41	11-52	29	10	6-36	37	22	10-37	17	47	18-62	22	23	9-45	56	27	10-32
PLEASANT VALLEY HOSP CAMARILLO CA 93010	CA-360	985	10	10-17	94	17	14-35	38	37	18-47	30	7	7-36	63	22	14-36	33	24	24-57	18	11	4-42	79	20	13-33
PLUMAS DISTRICT HOSP QUINCY CA 95971	CA-361*	157	12	7-19	6	33	4-67	3	67	3-83	5	0	2-69	9	33	4-55	6	0	9-75	3	0	2-82	33	12	8-36 6
POMEROO HOSPITAL POWAY CA 92064	CA-362	1233	11	8-15	130	19	14-32	39	26	15-43	39	21	7-33	60	28	13-34	57	35	27-53	26	12	6-38	74	26	12-32
POMONA VALLEY COMM HOSP POMONA CA 91767	CA-363	2690	13	9-16	198	29	18-35	123	37	22-39	67	25	10-32	131	21	16-32	81	41	31-53	53	17	9-33	255	22	15-27
PORTERVILLE DEVELOPMENTAL PORTERVILLE CA 93258	CA-364*	116	1	1-12	1	0	1-97	.	.	.	3	0	0-89	.	.	.	.	.	.	4	0	0-82	17	6	2-36
PRESBYTERIAN INTERCOMMUNIT WHITTIER CA 90602	CA-365	2756	11	9-15	225	27	17-33	94	34	20-39	47	19	8-32	158	20	16-30	86	36	27-49	55	25	11-36	206	23	15-29
PROVIDENCE HOSP OAKLAND CA 94623	CA-366*	2600	13	10-16	184	28	18-35	113	33	21-39	55	20	9-32	151	19	16-30	69	28	29-53	102	25	12-33	231	19	15-28
QUEEN OF ANGELS MEDICAL CE LOS ANGELES CA 90026	CA-367	1349	16	12-19	67	31	19-44	51	25	18-44	56	18	10-33	100	29	16-33	32	44	29-63	55	22	11-35	141	23	19-35
QUEEN OF THE VALLEY NAPA CA 94558	CA-368	1845	15	10-17	156	28	15-33	74	32	19-41	45	18	9-34	87	29	15-34	57	61	28-54	38	11	8-35	188	19	14-29
QUEEN OF THE VALLEY HOSP WEST COVINA CA 91790	CA-369	1723	15	11-17	115	41	20-40	78	41	19-40	57	14	7-29	113	19	15-32	72	36	28-52	32	22	9-40	171	23	13-27
RALPH K DAVIES MEDICAL CEN SAN FRANCISCO CA 94114	CA-370	892	10	10-18	78	14	14-36	65	15	19-42	34	21	8-36	47	17	14-39	27	26	23-60	13	15	3-45	89	22	13-31
RANCHO ENCINO HOSP ENCINO CA 91316	CA-371	598	16	10-18	43	35	14-42	14	21	11-57	15	0	6-47	47	19	14-39	15	40	24-72	22	32	9-46	54	24	12-35
REOBUD COMMUNITY HOSPITAL CLEARLAKE HIGHLANDS CA 95422	CA-372*	516	13	10-18	33	15	8-37	20	25	13-52	25	24	5-36	26	19	9-40	36	58	25-57	24	4	7-41	74	12	10-29
REDDING MEDICAL CENTER REDDING CA 96001	CA-373	1289	9	7-13	78	15	12-33	30	30	15-47	34	9	4-30	53	17	13-37	53	40	23-49	18	22	5-42	91	19	10-27
REDLANDS COMM HOSP REDLANDS CA 92373	CA-374	1851	15	10-16	163	14	13-29	84	23	20-40	60	25	9-31	92	23	15-33	79	44	30-53	67	31	12-35	133	35	15-31
REDWOOD MEMORIAL HOSPITAL FORTUNA CA 95540	CA-375	444	17	9-18	27	30	11-45	18	17	12-53	15	13	6-48	19	47	9-46	26	46	23-60	9	44	5-58	46	26	10-35
RIDEOUT MEM HOSP MARYSVILLE CA 95901	CA-376*	1305	16	9-16	101	29	17-37	72	43	18-40	30	30	8-37	77	25	14-34	45	51	23-52	34	21	7-36	127	22	13-29

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

CA-26

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
PENINSULA HDSP MEDICAL C BURLINGAME CA 94010	16	31	6-52	15	53	15-62	72	10	3-18	12	0	0-99	199	6	2-9	86	1	1-13	15	0	0-86	210	5	2-8	171	2	0-6
PERALTA HOSP DAKLAND CA 94609	11	18	8-61	9	56	12-70	33	9	2-24	139	1	0-7	121	3	2-11	56	5	1-16	9	0	0-98	61	3	1-14	112	1	1-8
PETALUMA VALLEY HOSPITAL PETALUMA CA 94952	5	20	4-74	10	50	13-68	43	12	3-23	2	0	0-100	89	7	2-14	49	4	1-17	13	0	0-78	78	3	2-13	57	2	0-14
PHS INDIAN HEALTH SERVICE WINTERHAVEN CA 92283	1	0	0-98	1	100	2-98	.	.	.	.	.	.	.	.	.	1	0	0-100	.	.	.	1	0	0-100	1	0	0-100
PICO RIVERA COMM HOSP PICO RIVERA CA 90660	8	63	8-68	1	0	1-97	12	0	2-43	.	.	.	36	6	2-21	28	11	5-32	4	25	0-100	51	16	2-17	7	0	0-89
PINECREST HOSP SANTA BARBARA CA 93105	.	.	.	1	0	1-97	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
PIDNEER HOSPITAL ARTESIA CA 90701	6	33	4-70	5	0	5-74	19	5	1-31	2	0	0-100	56	13	1-14	18	17	0-33	12	0	0-100	63	6	1-13	19	0	0-50
PIONEERS MEMORIAL HDSPITAL BRAWLEY CA 92227	10	10	3-56	8	25	10-70	16	6	2-37	2	0	0-100	43	7	1-17	13	23	1-40	5	0	0-100	65	0	2-14	25	4	0-27
PLACENTIA-LINDA COMM HOSP PLACENTIA CA 92670	7	29	7-70	7	0	10-72	21	10	1-29	3	0	0-100	61	3	1-13	25	8	1-26	1	0	0-100	59	2	1-14	41	0	0-24
PLEASANT VALLEY HDSP CAMARILLO CA 93010	8	25	9-69	4	75	7-83	33	6	4-29	5	0	0-100	95	2	2-13	63	2	1-15	13	0	0-88	76	5	2-13	64	2	0-11
PLUMAS DISTRICT HDSP QUINCY CA 95971	1	0	0-99	1	0	3-99	5	0	0-72	.	.	.	20	5	0-30	1	0	0-100	1	0	0-100	10	20	0-49	10	0	0-91
POMERADD HDSPITAL POWAY CA 92064	6	17	5-70	13	38	15-65	62	8	3-19	45	0	0-32	123	2	1-10	70	1	1-14	22	0	0-90	75	3	2-13	77	0	0-10
POMONA VALLEY COMM HDSP POMONA CA 91767	23	26	6-45	26	62	21-59	98	6	5-18	14	0	0-95	237	9	3-11	108	5	2-13	19	0	0-94	311	4	3-8	182	2	0-6
PORTERVILLE DEVELOPMENTAL PORTERVILLE CA 93258	1	0	0-100	.	.	.	2	0	0-96	2	0	0-100	8	0	0-76	5	0	0-98	5	0	0-100	3	0	0-95	15	0	0-95
PRESBYTERIAN INTERCOMMUNIT WHITTIER CA 90602	14	29	8-56	33	36	23-58	83	10	3-17	31	0	0-49	253	5	3-10	78	4	2-15	28	0	0-97	366	4	3-7	217	3	0-5
PROVIDENCE HDSP OAKLAND CA 94623	28	11	10-48	20	40	19-61	86	7	4-18	8	13	0-100	191	7	3-11	152	9	2-12	10	0	0-60	140	4	3-11	188	2	0-5
QUEEN OF ANGELS MEDICAL CE LOS ANGELES CA 90026	21	19	5-46	37	38	26-60	25	8	3-30	3	0	0-100	114	8	2-12	91	8	3-16	2	0	0-100	123	5	3-12	41	0	0-16
QUEEN OF THE VALLEY NAPA CA 94558	29	21	12-50	40	33	25-58	71	10	3-18	16	0	0-95	144	11	3-12	64	2	1-16	12	0	0-99	162	3	2-9	115	3	1-8
QUEEN OF THE VALLEY HDSP WEST CDVINA CA 91790	25	40	13-54	44	39	25-56	50	8	2-20	8	0	0-100	160	5	3-11	61	3	1-16	11	0	0-92	190	3	2-8	80	4	0-9
RALPH K DAVIES MEDICAL CEN SAN FRANCISCO CA 94114	5	20	1-71	12	33	17-69	23	4	2-29	13	0	0-93	63	3	2-16	25	0	2-28	2	0	0-100	57	2	1-15	53	0	0-13
RANCHD ENCINO HDSP ENCINO CA 91316	6	67	7-73	8	13	12-72	25	8	3-30	.	.	.	35	9	2-21	24	29	2-28	6	0	0-99	33	6	1-21	48	4	0-15
REDBUD COMMUNITY HOSPITAL CLEARLAKE HIGHLANDS CA 95422	5	20	11-83	5	20	6-76	22	5	2-30	1	0	0-100	42	2	2-19	14	0	0-42	5	0	0-100	59	2	1-13	30	3	0-22
REDDING MEDICAL CENTER REDDING CA 96001	12	25	7-58	6	33	15-82	39	5	3-23	2	0	0-100	118	6	2-11	69	1	0-15	30	0	0-55	139	4	2-10	113	0	0-7
REDLANDS COMM HDSP REDLANDS CA 92373	11	9	8-61	9	56	12-70	92	10	5-20	7	0	0-100	138	10	2-11	165	3	1-11	30	0	0-69	97	0	2-11	166	3	0-6
REDWOOD MEMORIAL HDSPITAL FORTUNA CA 95540	7	29	6-68	5	40	6-76	14	7	1-38	.	.	.	45	13	1-17	10	20	0-49	7	0	0-100	32	3	1-20	30	0	0-22
RIDEOUT MEM HDSP MARYSVILLE CA 95901	3	67	1-82	13	23	12-61	45	11	3-21	5	0	0-100	117	7	3-13	80	3	0-14	5	0	0-100	115	3	2-10	55	2	0-14

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		High Risk Diagnostic Categories																							
		Overall			Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
Name/Location	Comment/Reference																								
RIDGECREST COMM HOSP RIDGECREST CA 93555	CA-377*	477	9	8-16	23	30	9-44	14	14	10-55	23	35	8-43	33	6	12-42	15	40	17-64	6	0	2-64	64	8	8-28
RIO HONDO MEM HDSP DOWNEY CA 90240	CA-378*	850	14	9-17	65	32	13-36	28	21	12-45	30	13	5-33	51	39	16-40	13	31	17-67	37	14	6-33	107	20	12-29
RIVERSIDE COMMUNITY HDSP RIVERSIDE CA 92501	CA-379	2558	12	9-15	200	25	17-33	113	34	19-37	56	20	8-31	146	29	16-31	104	43	31-52	51	18	8-33	191	12	13-26
RIVERSIDE COMMUNITY HDSP-K RIVERSIDE CA 92506	CA-380*	46	D	0-19																					
RIVERSIDE GEN HOSP-UNIV ME RIVERSIDE CA 92503	CA-381	785	19	8-15	24	33	11-47	25	76	13-48	21	29	5-39	42	19	12-37	22	50	16-54	36	25	8-37	75	37	13-33
ROSEVILLE COMMUNITY HDSPIT ROSEVILLE CA 95678	CA-382*	1908	12	10-16	133	26	17-36	71	24	18-39	39	15	9-36	89	11	15-34	69	49	29-53	48	15	8-34	194	26	14-28
RDSS GEN HOSP RDSS CA 94957	CA-383	669	12	9-16	43	21	10-36	31	23	17-50	19	21	5-41	27	11	11-43	26	46	25-62	16	19	6-46	47	36	11-36
ROSS-LOOS HDSP OF LDS ANGE LDS ANGELES CA 90026	CA-384*	1029	12	9-17	96	21	14-34	49	18	16-42	32	19	9-39	56	23	16-40	18	28	17-60	26	31	12-47	67	22	14-35
SACRED HEART HDSP HANFORD CA 93230	CA-385	550	16	10-18	27	26	10-43	16	69	16-60	17	18	8-48	30	23	12-43	22	55	22-61	22	14	5-39	65	26	10-31
SADLEBACK COMM HOSP LAGUNA HILLS CA 92653	CA-386	3512	12	10-16	290	30	18-33	141	35	21-38	86	10	11-30	227	20	18-31	137	37	34-53	54	4	9-34	163	20	16-31
SAINT AGNES HDSP FRESNO CA 93710	CA-387*	4338	11	8-15	425	22	17-31	139	26	20-36	111	7	10-28	210	25	16-29	152	38	29-46	47	21	12-39	289	22	14-27
SAINT BERNARDINE MEDICAL C SAN BERNARDINO CA 92404	CA-388	3066	13	9-16	247	19	17-33	108	33	20-38	60	22	9-31	169	27	16-30	109	48	30-50	67	24	11-34	249	22	14-27
SAINT JUDE HOSP - YORBA LI FULLERTON CA 92635	CA-389	2382	11	9-15	211	22	17-34	86	37	20-41	51	18	9-33	134	17	16-31	56	27	24-50	53	34	14-41	148	20	13-28
SALINAS VALLEY MEM HOSP SALINAS CA 93901	CA-390*	1922	11	9-16	151	26	16-33	76	24	18-39	60	12	9-31	88	18	15-34	58	52	27-53	38	11	11-40	146	20	16-31
SAMUEL MERRITT HDSP DANFORD CA 94609	CA-391	2839	10	8-15	194	24	16-33	82	21	19-39	65	14	10-31	127	18	18-34	82	30	29-51	58	14	13-39	177	20	15-29
SAN ANTONIO COMMUNITY HOSP UPLAND CA 91786	CA-392	2473	13	10-17	156	31	17-34	96	33	22-42	49	20	10-35	161	30	18-32	121	42	31-50	44	25	10-37	191	25	14-28
SAN BERNARDINO CO MEDICAL SAN BERNARDINO CA 92404	CA-393	562	16	7-14	21	38	10-47	16	38	10-51	14	50	4-45	23	17	9-43	12	42	15-66	30	13	6-36	59	24	8-28
SAN BERNARDINO COMMUNITY H SAN BERNARDINO CA 92411	CA-394	1657	14	10-17	92	30	19-41	54	39	18-43	51	31	11-36	87	21	15-34	41	56	26-56	68	26	11-34	175	23	15-29
SAN CLEMENTE GENERAL HOSPI SAN CLEMENTE CA 92669	CA-395	963	17	12-19	78	23	13-34	59	36	20-44	29	34	8-39	75	28	15-34	57	32	26-52	32	13	9-40	83	30	14-33
SAN DIEGO PHYSICIANS SURG SAN DIEGO CA 92102	CA-396	414	14	8-17	11	55	9-59	16	38	11-54	9	33	3-53	33	6	11-39	22	55	26-66	26	19	5-36	40	20	9-34
SAN DIMAS COMM HDSP SAN DIMAS CA 91773	CA-397	720	12	9-17	46	30	14-41	40	18	14-42	21	19	5-40	68	26	14-35	26	62	25-63	25	0	6-39	50	12	10-34
SAN FERNANDO COMM HOSP SAN FERNANDO CA 91340	CA-398*	203	19	10-21	8	50	11-71	12	42	10-59	6	0	1-63	11	27	7-55	3	100	2-81	10	20	1-50	42	31	11-37
SAN FRANCISCO GEN HOSP SAN FRANCISCO CA 94110	CA-399*	1246	14	8-15	71	18	15-38	45	44	17-44	29	17	6-35	52	21	13-37	59	53	29-55	23	4	4-38	86	20	11-29
SAN GORGONIO PASS MEMORIAL BANNING CA 92220	CA-400*	866	14	10-18	38	26	10-39	43	30	16-44	19	21	3-38	55	20	13-36	46	48	27-55	35	9	7-36	81	22	14-34
SAN JACUIN COMM HDSP BAKERSFIELD CA 93301	CA-401	2214	13	9-15	182	32	20-37	75	35	18-39	28	25	8-39	79	19	14-33	96	42	26-47	41	34	13-41	160	27	15-30
SAN JACUIN GEN HOSP FRENCH CAMP CA 95231	CA-402	483	16	10-18	17	35	9-49	53	19	17-42	20	20	5-40	26	15	11-44	11	73	14-66	31	35	7-38	47	11	8-30

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

CA-28

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
RIOGECREST COMM HOSP RIOGECREST CA 93555	9	11	4-59	2	50	2-90	10	0	1-47	1	0	0-100	61	3	2-16	4	0	0-88	2	0	0-100	53	2	1-15	20	5	0-42
RIO HONDO MEM HOSP DOWNEY CA 90240	18	22	8-51	15	33	15-62	24	0	3-30				82	13	2-13	40	3	1-20	5	0	0-100	51	2	1-15	50	2	0-14
RIVERSIDE COMMUNITY HOSP RIVERSIDE CA 92501	33	18	8-44	28	14	16-52	110	8	4-16	39	0	0-47	217	6	3-10	83	2	1-13	26	0	0-97	208	3	2-9	176	1	0-5
RIVERSIDE COMMUNITY HOSP-K RIVERSIDE CA 92506																											
RIVERSIDE GEN HOSP-UNIV ME RIVERSIDE CA 92503	10	40	6-60	16	69	16-62	18	6	2-33	3	0	0-100	38	21	1-20	34	18	1-22	2	0	0-100	43	7	1-16	41	10	0-20
ROSEVILLE COMMUNITY HOSPIT ROSEVILLE CA 95678	18	22	9-53	31	19	20-56	57	4	3-19	1	0	0-100	172	5	3-10	85	7	2-14	11	0	0-100	191	9	3-10	104	0	0-8
ROSS GEN HOSP ROSS CA 94957	3	33	2-83	7	71	15-79	33	9	3-25	4	0	0-100	54	2	2-16	11	0	0-45	3	0	0-100	22	14	1-27	59	0	0-12
ROSS-LOOS HOSP OF LOS ANGE LOS ANGELES CA 90026	15	33	6-52	10	20	16-72	41	17	4-25	18	0	0-93	77	6	3-16	75	1	0-14	8	0	0-93	117	2	3-13	62	3	0-12
SACREO HEART HOSP HANFORD CA 93230	14	50	9-57	11	9	14-67	22	0	2-30				39	10	1-19	30	3	2-26	7	0	0-100	45	7	1-17	50	4	0-15
SAOOLEBACK COMM HOSP LAGUNA HILLS CA 92653	26	31	14-54	30	17	22-58	154	7	5-16	67	1	0-13	239	3	3-10	137	1	2-12	22	0	0-53	370	4	3-9	318	1	1-5
SAINT AGNES HOSP FRESNO CA 93710	37	30	10-45	27	44	20-57	122	5	4-16	20	0	0-92	380	4	3-8	160	4	1-11	73	0	0-38	649	7	3-7	328	2	0-4
SAINT BERNARDINE MEDICAL C SAN BERNARDINO CA 92404	23	26	8-47	25	40	19-57	96	11	6-21	40	0	0-34	246	10	4-11	116	3	1-12	27	0	0-86	498	6	4-8	191	2	0-5
SAINT JUOE HOSP - YORBA LI FULLERTON CA 92635	16	44	6-51	27	37	18-55	55	9	3-20	7	0	0-97	174	7	2-10	113	4	1-12	28	0	0-92	347	5	3-8	127	2	1-8
SALINAS VALLEY MEM HOSP SALINAS CA 93901	34	18	10-45	27	37	18-55	61	13	3-19	3	0	0-100	239	4	3-9	132	0	1-11	17	0	0-93	118	1	2-11	113	3	0-7
SAMUEL MERRITT HOSP OAKLAND CA 94609	14	14	5-53	19	58	21-65	78	5	6-21	2	0	0-100	188	6	3-11	72	3	2-15	17	0	0-68	526	6	4-8	302	2	0-4
SAN ANTONIO COMMUNITY HOSP UPLAND CA 91786	32	16	14-51	21	48	20-62	69	7	5-21	6	0	0-100	263	6	3-10	78	5	2-15	20	0	0-81	238	5	3-9	137	1	0-6
SAN BERNARDINO CO MEDICAL SAN BERNARDINO CA 92404	27	15	1-40	12	58	11-62	30	23	2-26	3	0	0-100	29	10	1-22	12	8	1-42	1	0	0-100	31	6	1-20	33	3	0-21
SAN BERNARDINO COMMUNITY H SAN BERNARDINO CA 92411	16	31	6-52	36	36	23-56	54	19	5-24	1	0	0-100	112	4	2-12	50	6	2-19	19	0	0-51	127	6	2-11	104	2	0-8
SAN CLEMENTE GENERAL HOSPI SAN CLEMENTE CA 92669	9	44	17-77	13	31	16-66	27	4	3-29	2	50	0-100	97	9	2-13	35	3	1-21	8	0	0-100	83	6	2-12	43	0	0-15
SAN DIEGO PHYSICIANS SURG SAN DIEGO CA 92102	1	0	0-98	7	43	9-71	6	0	1-63				27	11	1-23	31	0	1-23	1	0	0-100	25	8	1-24	13	0	0-72
SAN OIMAS COMM HOSP SAN OIMAS CA 91773	3	0	3-84	2	0	8-96	30	7	2-26	1	0	0-100	78	5	1-12	48	8	1-17	7	0	0-100	71	4	1-13	34	0	0-29
SAN FERNANDO COMM HOSP SAN FERNANDO CA 91340	3	67	10-91	6	67	11-78	3	0	0-87	1	0	0-100	7	0	0-64	12	8	2-43				13	0	0-39	7	0	0-99
SAN FRANCISCO GEN HOSP SAN FRANCISCO CA 94110	12	33	6-56	17	59	18-63	57	18	4-21	4	0	0-100	68	15	2-15	49	6	2-18	4	25	0-100	57	5	1-14	54	6	0-13
SAN GORGONIO PASS MEMORIAL BANNING CA 92220	14	21	6-53	17	35	16-60	39	8	4-25				90	3	2-12	33	3	1-22	11	0	0-89	89	7	2-13	43	0	0-15
SAN JOAQUIN COMM HOSP BAKERSFIELD CA 93301	9	22	5-61	16	31	13-58	44	16	3-23	50	0	0-23	210	8	3-10	61	3	2-17	30	0	0-83	479	4	3-7	32	0	0-19
SAN JOAQUIN GEN HDSP FRENCH CAMP CA 95231	10	40	8-63	7	57	11-74	9	11	1-50				23	17	1-26	21	5	1-29	5	0	0-100	17	6	0-32	19	5	0-39

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		High Risk Diagnostic Categories																									
		Overall			Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease				
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent		
Name/ Location	Comment/ Reference	SAN JOSE HOSPITAL SAN JOSE CA 95112	CA-403	2029	11	9-15	149	23	14-31	67	19	19-41	38	16	9-36	134	21	16-31	67	37	26-50	44	27	6-32	154	19	15-30
SAN LUIS OBISPO GEN HOSP SAN LUIS OBISPO CA 93401	CA-404*	236	10	5-15	9	33	7-61	4	25	2-75	4	0	0-76	8	0	3-57	4	50	5-79	4	0	3-76	13	8	6-50		
SAN PEDRO PENINSULA HOSP SAN PEDRO CA 90732	CA-405	1521	13	9-16	124	18	15-33	61	28	19-42	39	13	6-32	84	32	15-34	50	36	24-51	39	15	7-34	144	26	15-31		
SANGER HOSP SANGER CA 93657	CA-406*	148	11	7-19	4	75	5-79	3	67	4-85	6	0	2-63	9	33	8-62	2	100	3-91	9	0	2-53	24	13	8-41		
SANTA ANA HOSP MEDICAL CTR SANTA ANA CA 92706	CA-407*	545	19	9-17	18	28	10-50	14	14	10-55	17	29	6-45	14	29	7-50	2	50	6-94	11	55	6-55	105	39	15-33		
SANTA BARBARA COTTAGE HOSP SANTA BARBARA CA 93102	CA-408	3484	9	8-14	387	18	15-30	104	26	19-37	70	14	10-31	140	19	16-31	73	44	26-49	44	16	13-42	199	20	13-27		
SANTA CLARA VALLEY MEDICAL SAN JOSE CA 95128	CA-409	1237	15	8-15	64	30	16-40	29	41	12-43	36	39	9-36	37	19	13-41	53	43	25-52	23	30	6-40	103	31	12-29		
SANTA MARTA HOSP CLINIC LOS ANGELES CA 90022	CA-410*	405	18	11-21	16	31	11-54	19	47	12-52	17	24	4-40	22	32	11-47	29	55	25-61	18	22	6-44	55	16	14-38		
SANTA MONICA HOSP MEO CTR SANTA MONICA CA 90404	CA-411	2449	12	10-17	215	20	17-33	145	23	22-38	60	18	10-32	113	24	15-32	95	44	30-51	46	15	9-35	188	24	16-31		
SANTA PAULA MEM HOSP SANTA PAULA CA 93060	CA-412*	595	15	11-19	63	27	11-34	31	35	16-48	26	15	6-37	35	14	11-39	38	37	24-55	10	20	5-55	69	26	11-32		
SANTA ROSA MEM HOSP SANTA ROSA CA 95405	CA-413	3051	12	9-15	313	27	17-32	141	26	20-36	72	19	9-29	133	25	16-31	109	31	26-46	42	14	8-34	175	22	14-28		
SANTA TERESA COMM HOSP SAN JOSE CA 95119	CA-414	1160	10	8-15	78	22	15-37	37	24	13-41	34	21	10-39	60	27	16-38	48	38	22-49	28	18	10-43	83	19	10-28		
SANTA TERESITA HOSP OUARTE CA 91010	CA-415*	643	19	10-18	25	44	13-49	36	31	16-46	24	38	7-40	50	22	14-38	27	48	19-55	22	14	5-39	87	29	13-32		
SANTA YNEZ VALLEY HOSP SOLVANG CA 93463	CA-416*	239	10	8-18	16	31	13-57	8	50	8-66	6	17	1-63	19	11	8-46	14	21	16-64	3	0	1-82	15	13	4-44		
SCENIC GENERAL HOSP MODESTO CA 95350	CA-417*	384	13	8-17	29	24	12-45	8	0	6-62	11	18	4-50	28	14	11-42	17	65	16-59	18	28	4-41	53	9	9-31		
SCRIPPS CLINIC RESEARCH F LA JOLLA CA 92037	CA-418	1695	5	6-12	191	14	15-31	22	27	14-51	28	11	7-37	41	12	12-38	19	26	18-59	13	15	6-51	120	7	10-26		
SCRIPPS MEMORIAL HOSP - EN ENCINITAS CA 92024	CA-419	1281	10	9-16	101	26	15-35	40	33	15-43	32	13	8-37	61	18	15-37	48	31	25-53	46	7	9-36	120	20	11-27		
SCRIPPS MEMORIAL HOSP - LA LA JOLLA CA 92037	CA-420	3114	9	8-14	332	21	19-33	101	26	20-39	59	14	6-28	95	16	16-35	103	29	26-46	34	3	4-32	153	18	13-28		
SCRIPPS MEMORIAL HOSPITAL- CHULA VISTA CA 92010	CA-421	1519	13	10-17	92	23	15-36	55	31	18-42	50	18	6-29	98	22	16-33	55	47	29-55	56	13	8-32	167	11	13-27		
SEASIDE HOSP MEDICAL CLI CRESCENT CITY CA 95531	CA-422*	551	16	9-17	24	33	9-44	24	42	15-51	25	16	3-33	30	13	9-39	33	52	22-55	19	11	6-44	86	21	8-25		
SELMA DISTRICT HOSPITAL SELMA CA 93662	CA-423*	525	10	9-17	27	0	8-40	31	32	14-45	14	14	4-46	23	26	11-46	10	50	17-73	17	29	11-54	59	17	12-34		
SENECA DISTRICT HOSP CHESTER CA 96020	CA-424	100	7	6-20	2	100	4-92	3	33	2-82	3	0	0-82	2	0	1-89	5	20	9-78	4	0	1-75	21	0	4-36		
SEQUOIA HOSP REOWOOD CITY CA 94062	CA-425	2347	10	8-15	195	27	18-34	93	31	19-38	35	11	8-36	133	13	16-31	105	24	26-46	39	10	7-34	143	20	12-27		
SERRA MEMORIAL HOSPITAL SUN VALLEY CA 91352	CA-426	751	14	9-17	21	24	10-47	30	30	13-45	16	31	5-45	54	31	13-35	18	72	22-65	30	27	9-40	84	18	12-31		
SETON MEDICAL CENTER OALY CITY CA 94015	CA-427	2539	13	9-15	166	23	19-36	105	36	18-36	47	21	8-32	131	23	17-33	102	49	28-49	45	18	9-35	161	23	13-28		
SHARP CABRILLO HOSP SAN DIEGO CA 92110	CA-428	1561	10	7-14	113	27	15-34	40	23	16-44	29	14	6-35	71	20	14-34	46	46	24-53	43	2	8-35	125	25	12-27		

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

CA-30

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
SAN JOSE HOSPITAL SAN JOSE CA 95112	16	50	10-56	11	36	11-63	57	7	4-21	7	0	0-99	179	7	4-12	89	1	1-13	24	0	0-80	241	5	3-9	105	2	0-8
SAN LUIS OBISPO GEN HOSP SAN LUIS OBISPO CA 93401	3	0	2-83	1	0	3-99	9	22	1-50				14	0	1-37	5	0	0-80	7	0	0-100	11	9	1-44	8	13	0-68
SAN PEDRO PENINSULA HOSP SAN PEDRO CA 90732	16	19	9-55	14	71	16-65	31	6	3-26	11	0	0-100	128	9	3-12	128	2	2-12	19	0	0-87	113	4	2-11	104	0	1-8
SANGER HOSP SANGER CA 93657	2	0	0-90	1	100	1-97	3	0	0-82				20	0	0-32	10	10	0-48	3	0	0-100	12	0	0-48	3	0	0-100
SANTA ANA HOSP MEDICAL CTR SANTA ANA CA 92706	6	50	14-82	14	21	13-61	9	11	1-50	1	0	0-100	34	6	1-20	78	5	2-16	13	0	0-94	34	9	1-20	20	0	0-53
SANTA BARBARA COTTAGE HOSP SANTA BARBARA CA 93102	33	12	12-48	12	33	17-69	104	5	4-16	1	0	0-100	288	8	3-9	193	1	1-10	62	0	0-17	386	4	3-7	360	0	1-4
SANTA CLARA VALLEY MEDICAL SAN JOSE CA 95128	24	29	9-49	14	57	16-64	52	17	3-21	6	0	0-98	57	9	2-16	53	8	1-17	13	0	0-96	78	5	1-12	45	0	0-20
SANTA MARTA HOSP CLINIC LOS ANGELES CA 90022	4	0	6-81	4	75	6-81	7	0	0-58	1	0	0-100	33	0	2-22	11	9	0-45	1	0	0-100	47	2	1-16	9	0	0-88
SANTA MONICA HOSP MED CTR SANTA MONICA CA 90404	21	33	13-56	38	29	21-54	113	5	4-16	20	0	0-53	176	5	3-11	134	3	1-11	32	6	0-37	179	3	2-9	193	2	0-5
SANTA PAULA MEM HOSP SANTA PAULA CA 93060	4	0	1-76	18	17	14-57	28	4	4-31				43	14	1-18	20	0	0-31	4	0	0-100	43	2	2-19	48	0	0-14
SANTA ROSA MEM HOSP SANTA ROSA CA 95405	22	18	8-49	28	21	16-52	118	8	3-14	34	0	0-62	200	6	3-10	96	3	1-13	15	0	0-98	410	6	2-7	260	0	0-4
SANTA TERESA COMM HOSP SAN JOSE CA 95119	15	7	3-48	9	44	13-71	31	10	2-25	4	0	0-100	100	4	1-11	59	5	1-16	13	0	0-95	161	3	2-10	78	0	0-11
SANTA TERESITA HOSP DUARTE CA 91010	2	0	4-93	14	29	16-64	20	0	1-30	4	0	0-100	55	7	1-15	31	29	2-25	5	0	0-100	67	7	1-13	21	5	0-32
SANTA YNEZ VALLEY HOSP SOLVANG CA 93463	5	0	3-73	2	0	3-92	12	0	1-42				43	5	1-16	10	0	0-53	2	0	0-100	22	5	0-26	10	0	0-93
SCENIC GENERAL HOSP MODESTO CA 95350	4	0	2-76	3	33	3-83	10	0	0-48				37	11	2-20	15	0	0-45	4	0	0-100	20	0	0-29	16	0	0-65
SCRIPPS CLINIC RESEARCH F LA JOLLA CA 92037	13	0	6-55	2	50	2-90	17	0	1-34	34	0	0-56	116	4	2-11	57	2	0-16	31	0	0-74	121	2	2-10	321	0	0-4
SCRIPPS MEMORIAL HOSP - EN ENCINITAS CA 92024	12	25	7-57	16	25	13-58	47	4	2-20	6	0	0-100	111	5	2-11	61	5	1-16	14	0	0-44	93	5	2-12	110	0	0-7
SCRIPPS MEMORIAL HOSP - LA LA JOLLA CA 92037	23	26	13-54	26	42	22-60	87	7	4-17	49	0	0-42	282	4	3-9	131	2	1-11	46	0	0-61	469	4	3-8	306	2	0-4
SCRIPPS MEMORIAL HOSPITAL- CHULA VISTA CA 92010	14	29	12-62	20	30	14-56	51	6	3-21	2	0	0-100	125	10	3-13	72	3	1-15	21	5	0-81	136	6	2-11	69	0	0-10
SEASIDE HOSP MEDICAL CLI CRESCENT CITY CA 95531	7	0	2-63	11	55	10-62	21	14	1-30				52	2	1-15	13	0	0-43	2	50	0-100	52	12	1-14	45	2	0-19
SELMA DISTRICT HOSPITAL SELMA CA 93662	7	0	4-65	8	13	11-71	27	7	2-27				61	5	1-15	27	0	1-25	3	0	0-100	59	5	1-14	19	0	0-49
SENECA DISTRICT HOSP CHESTER CA 96020	2	50	3-91	1	0	0-97	1	100	0-99				13	0	0-40				2	0	0-100	11	0	0-50	3	0	0-100
SEQUOIA HOSP REOWOOD CITY CA 94062	14	7	7-54	18	6	18-62	81	9	3-16	5	0	0-100	191	7	2-9	72	0	0-14	26	4	0-76	353	3	3-8	159	3	0-6
SERRA MEMORIAL HOSPITAL SUN VALLEY CA 91352	10	30	7-61	26	19	20-58	20	10	3-33	2	0	0-100	65	5	2-15	26	4	2-27	5	0	0-100	80	0	1-12	32	3	0-21
SETON MEOICAL CENTER OALY CITY CA 94015	24	21	12-53	29	41	18-54	73	5	3-18	9	0	0-100	183	7	3-10	67	3	1-15	11	0	0-100	596	6	4-8	111	2	0-7
SHARP CABRILLO HOSP SAN DIEGO CA 92110	11	64	5-56	13	23	11-60	33	3	2-23	36	0	0-70	138	4	2-11	74	4	2-15	9	0	0-100	104	3	1-10	93	3	0-8

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		High Risk Diagnostic Categories																									
		Overall			Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease				
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent		
Name/Location	Comment/Reference	5HASTA GEN HOSP REDDING CA 96001	CA-429*	353	11	6-14	26	31	14-49	5	40	5-72	7	57	3-60	21	14	9-44	9	56	12-69	4	25	2-75	22	27	6-40
SHERMAN OAKS COMM HOSP CANOGA CA 91403	CA-430*	945	14	11-18	75	28	14-36	13	38	10-57	17	12	8-49	55	22	14-37	72	38	32-56	43	9	9-36	67	24	15-38		
SIERRA COMMUNITY HOSP FRESNO CA 93726	CA-431	855	9	6-13	62	16	14-37	25	20	12-46	21	24	4-38	36	39	11-38	18	44	18-61	7	0	4-64	58	24	11-33		
SIERRA NEVADA MEMORIAL HOSP GRASS VALLEY CA 95945	CA-432*	1419	12	10-17	108	28	14-34	61	31	20-43	40	18	6-31	62	31	13-34	79	33	29-52	39	8	8-36	178	14	14-28		
SIERRA VALLEY DISTRICT HOSP LOYALTON CA 96118	CA-433*	39	10	9-34	.	.	.	.	.	.	1	0	2-98	2	0	1-89	5	0	8-78	4	50	2-74	5	20	3-70		
SIERRA VIEW DISTRICT HOSP PORTERVILLE CA 93257	CA-434	1314	11	10-17	63	11	10-33	52	25	18-43	52	10	7-30	88	16	16-35	44	32	26-55	31	32	9-40	212	19	14-27		
SIERRA-KINGS HOSP REDDING CA 93654	CA-435*	263	15	9-19	16	38	14-58	11	18	10-61	6	0	3-65	23	35	11-46	7	57	12-75	14	0	2-43	26	12	11-44		
SIMI VALLEY ADVENTIST HOSP SIMI VALLEY CA 93065	CA-436*	519	12	9-17	30	23	12-45	22	45	15-52	11	0	5-53	42	24	12-37	16	69	19-64	12	25	4-50	41	22	8-32		
SISKIYOU GEN HOSP YREKA CA 96097	CA-437*	538	14	8-16	33	18	9-39	17	24	13-54	14	14	4-46	24	29	10-43	18	39	18-61	7	14	4-63	71	18	11-31		
SONOMA STATE HOSP-MED SURG ELORIOGE CA 95431	CA-438*	50	0	2-19	1	0	1-97	.	.	.	2	0	0-97	.	.	.	.	.	.	.	.	15	0	3-41			
SONOMA VALLEY HOSP SONOMA CA 95476	CA-439*	907	15	10-18	61	31	14-38	59	31	21-45	21	29	8-44	66	24	14-35	32	44	24-58	28	4	6-37	96	17	13-31		
SONORA COMM HOSP SONORA CA 95370	CA-440	747	9	8-16	42	19	11-39	34	18	16-47	13	23	4-47	35	20	13-42	28	14	18-53	18	6	4-41	87	9	11-29		
SOUTH BAY HOSP REDDING BEACH CA 90277	CA-441	980	17	11-19	86	36	19-41	51	35	17-43	43	28	10-36	59	29	16-39	38	58	24-55	46	24	11-38	92	21	11-29		
SOUTH COAST MEDICAL CENTER SOUTH LAGUNA CA 92677	CA-442	999	8	8-15	82	26	15-37	42	24	17-45	22	18	9-45	38	26	12-40	20	25	18-59	23	9	7-42	67	21	9-29		
SOUTHERN HUMBOLDT COMM HOSP GARBerville CA 95440	CA-443*	95	9	6-20	3	0	0-84	2	0	1-89	3	33	2-81	6	50	4-66	5	40	7-76	2	0	0-93	11	18	5-52		
SOUTHERN INYO HOSP LONE PINE CA 93545	CA-444*	97	9	8-23	1	100	0-99	3	33	5-85	2	0	0-92	8	0	6-62	3	0	5-86	5	20	2-69	22	14	7-41		
ST CATHERINE HOSPITAL MOSBY BEACH CA 94038	CA-445*	86	9	5-20	4	25	1-74	2	100	1-89	3	0	2-81	4	25	3-75	.	.	.	3	0	1-81	16	25	9-51		
ST ELIZABETH COMMUNITY HOSP RED BLUFF CA 96080	CA-446	802	12	9-17	53	19	12-37	34	26	18-50	35	6	6-32	51	33	15-39	30	53	21-55	23	4	7-42	82	12	11-30		
ST FRANCIS HOSP SANTA BARBARA CA 93103	CA-447	1121	12	9-16	73	25	14-36	57	28	19-43	24	21	6-39	56	23	14-37	40	53	26-56	27	11	8-41	83	17	13-32		
ST FRANCIS MEDICAL CENTER LYNWOOD CA 90262	CA-448*	2601	14	10-16	148	31	19-37	128	31	21-38	53	17	9-33	200	19	16-29	91	44	28-49	50	28	10-35	252	29	14-27		
ST FRANCIS MEMORIAL HOSP SAN FRANCISCO CA 94109	CA-449	1755	12	10-16	180	24	17-34	86	33	19-39	62	19	9-31	116	16	16-32	59	47	28-53	39	10	8-36	121	20	13-30		
ST HELENA HOSP HEALTH CE OBER PARK CA 94576	CA-450	1307	9	7-14	57	18	11-35	42	24	16-44	21	19	9-45	48	29	12-36	51	29	25-52	16	38	6-48	73	14	12-32		
ST JOHN'S REGIONAL MEDICAL OXNARD CA 93030	CA-451	2019	13	10-16	180	31	19-36	98	29	20-39	49	16	11-37	92	24	15-33	60	45	26-52	47	15	10-36	181	19	13-27		
ST JOHNS HOSP HEALTH CENTE SANTA MONICA CA 90404	CA-452	3650	9	8-14	361	16	17-32	119	26	21-39	62	19	9-31	134	13	18-33	94	36	33-54	44	20	9-35	241	21	15-28		
ST JOSEPH HOSP EUREKA CA 95501	CA-453*	1151	16	10-18	109	29	17-36	47	32	17-44	29	17	8-39	59	24	14-37	40	48	22-53	34	21	11-43	107	26	14-31		
ST JOSEPH HOSP ORANGE CA 92668	CA-454	3057	10	8-14	264	28	19-35	86	30	20-40	68	10	9-30	129	29	15-30	69	29	28-52	38	13	9-38	191	21	13-27		

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

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HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
SHASTA GEN HOSP REDDING CA 96001	2	50	1-90	1	100	0-97	2	0	0-92	.	.	.	28	7	1-22	18	6	0-39	8	0	0-95	13	8	0-39	44	0	0-20
SHERMAN OAKS COMM HOSP CANOGA CA 91403	5	20	3-72	15	33	18-66	35	11	4-27	5	0	0-100	43	7	1-18	51	4	1-17	5	0	0-100	69	4	2-14	86	0	0-9
SIERRA COMMUNITY HOSP FRESNO CA 93726	11	9	3-54	7	14	9-70	51	6	2-19	.	.	.	94	5	2-12	58	0	0-16	17	0	0-94	44	5	1-16	139	2	0-6
SIERRA NEVADA MEMORIAL HOS GRASS VALLEY CA 95945	11	18	10-65	24	29	19-58	55	7	2-19	1	0	0-100	124	5	2-10	55	2	1-16	21	0	0-87	140	3	2-10	104	1	0-8
SIERRA VALLEY DISTRICT HOS LOYALTON CA 96118	1	100	2-100	2	0	3-91	.	.	.	.	.	.	4	0	0-84	1	0	0-99	.	.	.	7	0	0-74	1	0	0-100
SIERRA VIEW DISTRICT HOSP PORTERVILLE CA 93257	7	43	9-73	13	46	17-68	40	8	4-25	1	0	0-100	148	3	3-11	81	1	1-14	15	0	0-97	109	4	3-12	52	2	0-13
SIERRA-KINGS HOSP REDDOLEY CA 93654	2	0	1-90	1	0	0-97	9	22	1-50	.	.	.	38	5	1-19	11	9	0-49	4	0	0-100	27	7	1-23	7	14	0-81
SIMI VALLEY ADVENTIST HOSP SIMI VALLEY CA 93065	9	0	4-59	2	0	3-91	9	11	1-50	3	0	0-100	42	5	2-19	15	13	1-37	3	0	0-100	57	2	1-14	14	0	0-69
SISKIYOU GEN HOSP YREKA CA 96097	9	22	8-66	1	0	1-97	16	6	2-36	1	0	0-100	53	13	1-15	21	5	1-29	7	0	0-100	48	6	1-15	50	8	1-14
SONOMA STATE HOSP-MED SURG ELORIDGE CA 95431	1	0	0-100	.	.	.	1	0	0-100	1	0	0-100	3	0	0-97	2	0	0-100	.	.	.	2	0	0-100	1	0	0-100
SONOMA VALLEY HOSP SONOMA CA 95476	5	40	5-75	4	75	10-85	42	5	4-24	3	0	0-100	86	6	2-14	47	15	3-21	5	0	0-100	80	6	2-13	71	1	0-10
SONORA COMM HOSP SONORA CA 95370	10	50	9-65	6	17	9-75	25	8	1-27	1	0	0-100	79	1	2-13	30	3	1-23	8	0	0-100	75	3	1-11	52	2	0-17
SOUTH BAY HOSP REDONDO BEACH CA 90277	12	8	7-58	13	38	14-63	37	8	3-24	4	0	0-100	90	11	2-14	31	3	1-23	12	8	0-73	70	3	2-13	43	0	0-16
SOUTH COAST MEDICAL CENTER SOUTH LAGUNA CA 92677	7	0	4-66	4	25	7-82	30	0	3-26	12	0	0-95	75	1	2-14	38	3	0-20	4	0	0-100	77	4	2-13	85	0	0-9
SOUTHERN HUMBOLDT COMM HOS GARBERVILLE CA 95440	2	0	1-90	.	.	.	.	.	.	.	.	.	7	14	0-58	.	.	.	2	0	0-100	13	0	0-39	4	0	0-91
SOUTHERN INYO HOSP LOVE PINE CA 93545	2	0	1-90	2	50	2-90	1	0	0-99	.	.	.	7	14	0-76	3	0	2-81	.	.	.	13	8	0-39	3	0	0-99
ST CATHERINE HOSPITAL MOSS BEACH CA 94038	.	.	.	1	0	0-97	.	.	.	.	.	.	9	0	0-62	4	0	0-94	.	.	.	1	0	0-100	.	.	.
ST ELIZABETH COMMUNITY HOS RED BLUFF CA 96080	8	25	9-69	3	0	5-86	32	13	3-27	2	0	0-100	93	9	2-13	39	5	1-20	11	0	0-86	63	5	2-15	49	0	0-14
ST FRANCIS HOSP SANTA BARBARA CA 93103	3	0	0-85	9	33	10-67	47	11	4-23	92	3	0-11	90	4	3-14	52	0	1-17	15	0	0-94	72	10	2-15	90	0	0-8
ST FRANCIS MEDICAL CENTER LYNWOOD CA 90262	27	41	14-54	31	42	21-56	49	8	4-22	14	0	0-99	202	8	3-11	152	10	2-13	23	0	0-60	249	4	2-8	123	1	0-7
ST FRANCIS MEMORIAL HOSP SAN FRANCISCO CA 94109	14	36	8-56	16	6	20-67	64	8	3-18	19	0	0-82	101	4	2-12	62	3	1-16	3	0	0-100	91	2	2-12	183	1	1-6
ST HELENA HOSP HEALTH CE OBER PARK CA 94576	6	17	7-73	5	20	12-83	34	12	2-23	2	0	0-100	64	3	2-15	40	3	2-21	8	0	0-100	322	4	3-9	54	4	0-13
ST JOHN'S REGIONAL MEDICAL OXNARD CA 93030	36	19	7-41	19	37	16-59	49	4	3-21	22	0	0-71	186	3	3-11	117	3	1-12	25	0	0-50	158	9	2-10	107	5	0-7
ST JOHNS HOSP HEALTH CENTE SANTA MONICA CA 90404	20	25	7-49	25	36	21-60	116	6	4-17	89	0	0-12	284	5	3-9	182	2	1-10	42	0	0-70	265	5	2-8	416	0	1-4
ST JOSEPH HOSP EUREKA CA 95501	10	10	12-68	22	27	19-60	27	11	2-27	2	0	0-100	92	8	2-13	40	3	1-20	12	8	0-75	105	13	2-12	92	2	0-9
ST JOSEPH HOSP ORANGE CA 92668	33	12	4-39	27	26	23-60	89	6	4-17	52	0	0-26	250	4	2-9	156	2	2-11	39	0	0-27	327	5	3-8	329	1	0-4

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		High Risk Diagnostic Categories																							
		Overall			Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
ST JOSEPH MEDICAL CTR BURBANK CA 91505	CA-455*	4407	13	10-16	399	27	21-35	183	16	21-36	95	20	10-29	232	23	18-31	139	27	29-47	115	23	15-35	367	26	16-28
ST JOSEPH'S HOSPITAL OF ST STOCKTON CA 95204	CA-456	3767	14	10-16	307	29	20-35	150	33	21-37	91	16	9-28	204	17	17-30	121	33	30-49	97	27	14-35	329	20	14-26
ST JOSEPH'S OAK PARK HOSP STOCKTON CA 95204	CA-457'	150	17	12-26	12	17	9-58	9	22	11-66	4	25	1-74	7	29	3-60	.	.	.	12	50	10-60	30	23	14-46
ST LUKE HOSP OF PASAONA PASAONA CA 91109	CA-458	1209	16	11-18	79	42	14-36	41	39	18-46	47	21	10-34	78	24	14-34	52	54	30-58	35	23	8-36	118	19	13-30
ST LUKES HOSP SAN FRANCISCO CA 94110	CA-459	1345	12	10-17	126	21	16-34	65	25	18-40	46	7	6-30	95	17	15-33	53	43	28-55	44	18	8-35	121	13	12-27
ST MARY DESERT VALLEY HOSP APPLE VALLEY CA 92307	CA-460*	1446	12	8-15	85	19	15-36	48	33	17-42	47	13	9-34	59	37	13-34	52	44	25-52	72	24	9-31	151	17	10-24
ST MARY MEDICAL CTR LONG BEACH CA 90801	CA-461	2017	12	9-16	146	21	19-37	64	34	19-43	30	27	6-36	106	24	17-34	55	44	27-54	39	10	6-33	176	23	12-26
ST MARY'S HOSP MED CTR SAN FRANCISCO CA 94117	CA-462	2503	10	8-15	178	19	17-34	69	26	20-42	56	9	9-32	144	14	17-32	68	41	28-53	34	6	6-35	158	22	15-30
ST ROSE HOSP HAYWARD CA 94545	CA-463	1060	17	10-18	57	25	14-39	63	30	17-40	24	33	8-41	57	28	13-35	59	58	28-54	39	15	6-33	134	23	13-29
ST VINCENT MEDICAL CENTER LOS ANGELES CA 90057	CA-464	2766	10	8-14	210	34	17-33	64	31	20-43	59	15	11-34	99	26	16-34	51	43	26-53	36	19	10-40	168	19	16-31
STANFORD UNIVERSITY HOSPIT PALO ALTO CA 94305	CA-465	3741	11	8-15	449	18	17-31	104	32	21-40	70	21	10-31	150	20	16-31	122	39	29-48	57	19	12-37	179	24	13-26
SURPRISE VALLEY COMMUNITY CEARVILLE, CA 96104	CA-466*	24	17	7-39	1	0	3-100	3	33	7-88	.	.	.	1	0	1-97	.	.	.	1	0	0-98	1	0	0-97
SUTTER OAVIS HOSP OAVIS CA 95616	CA-467*	478	14	9-17	29	21	7-37	26	42	16-51	18	17	5-41	21	24	10-47	10	40	13-68	19	21	6-43	58	21	12-34
SUTTER GEN HOSP-ARTIFICIAL SACRAMENTO CA 95816	CA-468*	2882	10	9-16	248	17	15-31	164	24	21-37	81	15	11-32	155	17	16-30	92	34	31-53	77	12	8-29	232	23	15-28
SUTTER MEM HOSP SACRAMENTO CA 95819	CA-469*	2366	9	9-15	266	24	16-32	34	32	18-50	28	21	6-37	117	20	16-32	110	18	29-49	23	13	11-48	73	19	13-34
SUTTER SOLANO MEDICAL CENT VALLEJO CA 94590	CA-470	982	18	10-17	64	30	12-34	67	25	17-39	31	13	6-34	51	25	13-37	41	56	26-56	37	16	7-34	91	25	12-30
TAHOE FOREST HOSPITAL OIST TRUCKEE CA 95734	CA-471*	264	6	6-16	11	36	14-66	4	0	3-76	7	0	2-60	10	10	5-54	12	17	13-63	5	40	6-76	31	10	7-35
TEHACHAPI DISTRICT HOSPITA TEHACHAPI CA 93561	CA-472*	125	12	7-21	6	67	9-75	6	33	6-69	2	0	0-93	10	30	4-53	5	0	12-82	6	17	2-65	16	13	5-43
TEMPLE COMMUNITY HOSPITAL LOS ANGELES CA 90004	CA-473	617	11	9-17	26	15	11-45	14	0	13-59	11	45	7-56	29	17	13-45	8	25	17-77	15	27	11-57	80	23	13-33
TORRANCE MEMORIAL MED CTR TORRANCE CA 90509	CA-474	2119	14	9-16	188	26	17-34	47	32	17-43	42	33	10-37	99	27	18-36	73	42	25-48	45	22	10-36	159	34	16-31
TRACY COMMUNITY MEMORIAL H TRACY CA 95376	CA-475*	654	13	9-17	47	19	15-42	32	25	15-47	14	14	3-43	40	20	12-38	23	39	20-58	15	20	9-52	59	19	11-33
TRI CITY MEDICAL CENTER OCEANSIDE CA 92054	CA-476	3708	11	10-16	337	25	17-32	152	28	22-38	100	11	10-28	179	17	17-30	128	41	31-49	67	13	11-35	328	18	15-27
TRINITY GENERAL HOSP WEAVERVILLE CA 96093	CA-477	84	10	5-20	4	-50	3-77	1	0	1-97	4	0	0-75	1	0	0-98	1	0	1-97	3	0	1-81	12	8	4-49
TULARE DISTRICT HOSPITAL TULARE CA 93274	CA-478*	863	13	9-16	45	38	11-37	23	13	14-51	19	11	5-42	45	29	15-40	36	58	23-55	17	41	9-51	87	20	13-32
TUOLUMNE GENERAL HOSP SONORA CA 95370	CA-479*	369	12	9-18	40	15	11-39	7	57	11-73	11	18	5-53	19	21	7-43	23	35	19-58	8	0	1-56	25	16	10-43
TUSTIN COMMUNITY HOSPITAL TUSTIN CA 92680	CA-480*	579	13	9-17	32	22	14-45	26	23	15-49	15	20	5-46	35	37	12-40	25	52	22-60	13	15	7-53	49	27	10-33

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

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HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
ST JOSEPH MEDICAL CTR BURBANK CA 91505	29	24	9-46	34	26	23-58	125	7	4-15	42	0	0-29	373	9	3-9	195	6	3-12	38	0	0-49	389	8	3-8	317	3	1-4
ST JOSEPH'S HOSPITAL OF ST STOCKTON CA 95204	47	30	15-49	45	36	21-52	107	15	5-18	4	0	0-100	294	6	3-10	152	5	1-11	63	0	0-43	478	8	3-7	199	3	0-5
ST JOSEPH'S OAK PARK HOSP STOCKTON CA 95204	4	50	8-84	7	29	7-68	.	.	.	.	.	.	9	0	0-56	5	0	0-69	.	.	.	2	50	0-94	7	0	0-90
ST LUKE HOSP OF PASADENA PASADENA CA 91109	17	12	9-54	18	33	20-64	65	6	4-20	.	.	.	109	8	3-13	56	16	3-20	2	0	0-100	105	3	2-12	73	3	0-10
ST LUKES HOSP SAN FRANCISCO CA 94110	14	29	10-59	16	25	18-65	40	10	4-25	6	0	0-100	111	8	2-11	48	2	1-17	9	0	0-100	84	8	2-12	75	3	0-10
ST MARY DESERT VALLEY HOSP APPLE VALLEY CA 92307	19	26	9-53	16	31	14-59	55	5	3-20	.	.	.	107	6	1-11	88	1	1-13	19	0	0-98	140	4	2-10	132	0	0-6
ST MARY MEDICAL CTR LONG BEACH CA 90801	17	18	10-55	38	45	20-53	71	6	5-21	6	0	0-100	162	7	3-11	94	7	1-13	21	0	0-53	186	8	3-10	115	3	0-7
ST MARY'S HOSP MED CTR SAN FRANCISCO CA 94117	16	6	5-50	29	28	24-61	78	15	4-19	86	0	0-13	190	5	4-12	63	6	1-16	14	0	0-99	277	8	3-9	265	0	1-5
ST ROSE HOSP HAYWARD CA 94545	5	0	1-71	20	60	17-59	28	7	3-27	.	.	.	100	6	1-11	58	17	3-19	8	0	0-100	88	3	2-12	57	5	0-13
ST VINCENT MEDICAL CENTER LOS ANGELES CA 90057	74	14	4-33	21	29	17-57	53	2	3-20	23	0	0-54	181	4	3-11	104	3	2-13	8	0	0-100	611	6	4-8	169	1	0-6
STANFORD UNIVERSITY HOSPIT PALO ALTO CA 94305	26	35	7-45	30	37	22-58	129	9	5-17	87	0	0-10	226	5	3-10	144	1	1-11	55	2	0-28	324	7	3-8	325	2	1-5
SURPRISE VALLEY COMMUNITY CEORVILLE, CA 96104	1	0	1-97	.	.	.	.	.	.	.	.	.	3	67	0-82	.	.	.	.	.	.	4	0	0-81	.	.	.
SUTTER OAVIS HOSP OAVIS CA 95616	4	0	4-79	9	22	8-64	19	0	3-36	.	.	.	45	9	1-18	16	6	0-37	2	0	0-100	44	2	1-17	41	5	0-16
SUTTER GEN HOSP-ARTIFICIAL SACRAMENTO CA 95816	16	25	4-49	25	44	22-61	163	4	4-15	42	0	0-38	206	4	3-11	165	1	1-11	10	0	0-89	109	2	2-12	347	1	1-4
SUTTER MEM HOSP SACRAMENTO CA 95819	22	18	4-43	17	29	18-64	6	33	1-62	3	0	0-100	110	5	2-12	41	5	1-19	54	0	0-34	726	5	4-8	22	5	0-30
SUTTER SOLANO MEDICAL CENT VALLEJO CA 94590	15	33	9-56	19	58	18-61	39	10	3-23	2	0	0-100	86	15	2-12	39	13	3-24	9	0	0-100	80	5	2-13	52	0	0-14
TAHOE FOREST HOSPITAL DIST TRUCKEE CA 95734	3	0	1-82	1	0	0-97	9	0	1-50	1	0	0-100	21	5	1-28	16	0	0-47	2	0	0-100	37	0	1-18	23	4	0-28
TEHACHAPI DISTRICT HOSPITA TEHACHAPI CA 93561	4	25	8-84	1	100	1-97	.	.	.	.	.	.	18	6	0-32	4	0	0-97	3	0	0-100	11	0	0-46	1	0	0-100
TEMPLE COMMUNITY HOSPITAL LOS ANGELES CA 90004	16	13	4-48	9	22	14-72	1	0	0-98	4	0	0-100	55	11	3-18	30	7	2-25	.	.	.	79	3	2-12	31	3	0-25
TORRANCE MEMORIAL MED CTR TORRANCE CA 90509	14	29	4-50	37	35	24-57	51	4	3-20	29	0	0-67	211	3	3-10	91	4	2-15	22	0	0-87	261	5	3-8	138	4	0-6
TRACY COMMUNITY MEMORIAL H TRACY CA 95376	8	38	7-67	10	50	18-75	19	5	1-31	2	0	0-100	60	7	2-15	16	6	1-35	3	0	0-100	64	5	1-13	53	0	0-13
TRI CITY MEDICAL CENTER OCEANSIDE CA 92054	18	11	11-56	16	13	16-62	129	7	5-17	34	0	0-47	382	4	4-9	160	3	2-11	43	0	0-29	331	5	3-9	231	2	1-6
TRINITY GENERAL HOSP WEAVERVILLE CA 96093	3	0	1-82	1	100	2-99	.	.	.	.	.	.	11	0	0-46	3	0	0-96	.	.	.	13	0	0-39	3	0	0-100
TULARE DISTRICT HOSPITAL TULARE CA 93274	6	50	9-76	13	23	17-67	21	5	2-31	2	0	0-100	63	8	2-15	29	0	1-24	5	0	0-100	95	0	2-11	34	0	0-23
TUOLUMNE GENERAL HOSP SONORA CA 95370	5	20	2-71	5	0	6-76	23	13	3-31	.	.	.	33	6	2-22	24	4	0-29	3	0	0-100	35	11	1-20	40	0	0-18
TUSTIN COMMUNITY HOSPITAL TUSTIN CA 92680	4	0	2-76	1	100	2-98	18	6	2-34	6	0	0-100	64	9	2-16	35	3	1-21	12	0	0-85	51	4	2-16	30	0	0-26

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		High Risk Diagnostic Categories																									
		Overall			Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease				
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent		
Name/ Location	Comment/ Reference	TWIN CITIES COMMUNITY HOSP TEMPLETON CA 93465	CA-481	880	12	9-17	66	20	14-37	38	29	18-48	31	26	12-43	41	20	11-37	31	45	20-54	31	19	7-38	89	18	12-30
U C L A HOSP CTR FOR HEALT LOS ANGELES CA 90024	CA-482	2870	7	8-14	307	12	20-35	34	32	18-49	31	19	5-33	95	19	16-34	59	32	27-53	48	15	12-38	119	18	15-31		
U C L A NEUROPSYCHIATRIC H LOS ANGELES CA 90024	CA-483*	110	3	4-16	.	.		25	4	12-46	1	100	0-100							1	0	0-98	.	.			
UKIAH ADOVENTIST HOSPITAL UKIAH CA 95482	CA-484	652	12	9-17	61	20	13-37	20	15	14-53	21	5	5-39	40	28	12-38	16	31	20-66	14	21	5-47	62	29	12-34		
UKIAH GENERAL HOSP UKIAH CA 95482	CA-485	506	15	10-19	72	24	16-39	31	29	14-46	5	40	2-69	29	28	10-41	18	44	19-62	8	0	6-64	33	33	11-40		
UNIV OF CA OAVIS - MEO CTR SACRAMENTO CA 95817	CA-486*	1778	12	8-14	168	29	19-37	34	38	13-43	30	17	10-41	51	20	13-36	43	58	24-53	37	19	8-36	125	21	13-29		
UNIV OF CALIF-IRVINE MEO C ORANGE CA 92668	CA-487	966	8	5-12	90	21	14-35	20	45	12-50	18	28	7-45	16	6	6-44	16	19	18-64	17	6	2-39	36	19	7-33		
UNIVERSITY HOSPITAL UCSO M SAN DIEGO CA 92103	CA-488	1553	9	7-14	174	22	19-37	32	22	12-42	28	14	7-37	44	23	12-37	37	19	21-51	31	3	5-35	94	21	11-28		
UNIVERSITY OF CALIF AT SAN SAN FRANCISCO CA 94143	CA-489	2678	7	7-14	332	10	16-30	54	31	15-39	27	11	9-42	52	21	14-38	103	31	28-49	26	12	6-38	92	15	11-29		
US AIR FORCE HOSP FAIRFIELD CA 94535	CA-490*	1	0	0-100	.	.		.	.		.	.		.	.		.	.		.	.		.	.			
US NAVAL HOSP OAKLAND CA 94614	CA-491*	1	100	0-100	.	.		.	.		.	.		.	.		.	.		.	.		.	.			
US NAVAL HOSP SAN DIEGO CA 92134	CA-492*	1	0	0-100	.	.		.	.		.	.		.	.		.	.		.	.		.	.			
VALLEY COMM HOSP SANTA MARIA CA 93454	CA-493*	516	13	8-17	29	41	12-45	14	14	11-57	9	22	3-54	26	27	11-44	25	40	21-58	17	29	10-52	44	20	11-36		
VALLEY COMMUNITY HOSPITAL WILLOWS CA 95988	CA-494*	242	20	8-19	9	67	9-64	3	33	2-81	9	22	3-55	18	33	10-50	10	40	16-71	4	25	0-75	45	33	10-35		
VALLEY HOSP POMONA CA 91767	CA-495*	35	0	0-23	1	0	0-99	1	0	0-97												1	0	0-98			
VALLEY HOSPITAL MEDICAL CE VAN NUYS CA 91405	CA-496	1184	13	8-15	58	17	12-36	33	21	15-45	14	43	5-47	58	34	14-37	23	26	22-61	37	24	7-35	126	36	15-32		
VALLEY MEO CENTER FRESNO CA 93702	CA-497	1333	16	9-16	52	46	19-46	41	49	17-45	54	22	8-31	69	16	14-35	59	32	29-55	40	23	8-35	131	32	14-30		
VALLEY MEMORIAL HOSP LIVERMORE CA 94550	CA-498	909	14	9-16	66	32	11-34	37	43	16-46	29	34	7-38	46	22	13-39	49	51	27-54	20	5	5-41	63	21	11-32		
VALLEY PARK MEDICAL CTR CANOGA PARK CA 91307	CA-499	166	30	11-24	9	78	20-78	7	14	9-70	1	0	1-97	10	20	6-55	9	56	15-72	10	60	15-70	11	45	7-56		
VALLEY PRESBYTERIAN HOSPIT VAN NUYS CA 91406	CA-500	2335	12	9-16	244	24	17-33	72	19	21-43	55	13	8-31	104	30	17-35	64	31	29-54	38	18	7-34	172	23	14-28		
VAN NUYS COMMUNITY HOSPITA VAN NUYS CA 91401	CA-501	294	25	11-21	17	24	7-47	8	25	9-66	5	0	1-68	24	33	12-47	7	100	18-81	10	30	3-52	71	39	15-36		
VENTURA COUNTY MED CTR VENTURA CA 93003	CA-502	584	16	7-15	27	37	11-45	20	35	12-50	18	11	6-43	27	44	10-41	20	55	20-61	14	29	3-45	59	22	11-33		
VEROUGO HILLS HOSP GLENDALE CA 91209	CA-503	1524	15	9-16	135	33	17-36	57	35	18-42	45	9	7-32	67	19	13-34	51	53	27-54	29	21	5-34	133	26	12-28		
VICTOR VALLEY COMM HOSP VICTORVILLE CA 92392	CA-504*	989	14	10-17	81	27	15-37	38	39	14-43	25	20	7-39	54	24	13-36	57	53	26-53	35	23	9-38	106	16	12-29		
VILLA VIEW COMMUNITY HOSP SAN DIEGO CA 92115	CA-505	557	15	9-17	33	24	13-45	15	47	11-55	18	22	6-43	30	33	11-42	21	57	22-63	21	5	6-42	57	30	11-33		
VISALIA COMMUNITY HOSP VISALIA CA 93277	CA-506	523	11	8-16	25	28	8-42	18	6	12-52	23	22	4-36	30	17	10-40	29	48	25-60	21	10	2-36	32	22	8-35		

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

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HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
TWIN CITIES COMMUNITY HOSP TEMPLETON CA 93465	3	33	1-82	14	21	11-58	32	9	4-28	10	0	0-100	86	6	2-13	64	2	1-15	18	0	0-100	76	0	2-12	55	0	0-13
U C L A HOSP CTR FOR HEALT LOS ANGELES CA 90024	63	6	3-33	13	62	22-73	45	9	4-23	116	1	0-7	134	2	3-13	92	3	1-13	65	0	0-20	204	5	3-11	173	1	0-6
U C L A NEUROPSYCHIATRIC H LOS ANGELES CA 90024	.	.	.	.	.	.	.	.	.	3	0	0-100	1	0	0-100	1	0	0-100	.	.	.	.	.	.	7	0	0-92
UKIAH ADVENTIST HOSPITAL UKIAH CA 95482	3	33	1-82	5	40	11-82	26	23	3-30	2	0	0-100	49	4	2-19	38	8	1-21	5	0	0-77	51	2	1-15	46	2	0-16
UKIAH GENERAL HOSP UKIAH CA 95482	6	83	11-78	9	44	12-69	21	10	1-30	.	.	.	47	2	1-16	22	0	1-28	3	0	0-100	22	0	0-26	39	3	0-19
UNIV OF CA DAVIS - MEO CTR SACRAMENTO CA 95817	23	4	5-44	14	64	10-57	42	12	3-23	80	0	0-15	108	7	2-12	82	5	1-14	15	0	0-93	92	10	2-12	89	2	0-9
UNIV OF CALIF-IRVINE MEO C ORANGE CA 92668	15	0	1-48	2	50	2-90	21	29	1-29	5	0	0-100	50	8	1-16	27	15	1-25	12	0	0-98	67	3	2-14	48	4	0-15
UNIVERSITY HOSPITAL UCSD M SAN DIEGO CA 92103	31	6	2-38	2	50	2-90	35	26	3-24	23	0	0-81	69	13	3-16	63	5	1-15	17	0	0-86	137	5	2-10	89	0	0-9
UNIVERSITY OF CALIF AT SAN SAN FRANCISCO CA 94143	93	1	2-32	7	57	10-73	35	9	3-25	54	0	0-25	198	6	4-13	81	2	1-13	26	4	0-46	192	7	3-10	233	0	0-5
US AIR FORCE HOSP FAIRFIELD CA 94535	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	
US NAVAL HOSP OAKLAND CA 94614	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	
US NAVAL HOSP SAN DIEGO CA 92134	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	
VALLEY COMM HOSP SANTA MARIA CA 93454	6	33	4-69	3	67	7-88	16	19	2-37	8	0	0-100	72	7	2-14	20	10	0-31	10	0	0-100	44	0	1-16	29	0	0-31
VALLEY COMMUNITY HOSPITAL WILLOWS CA 95988	1	0	0-98	2	0	3-91	7	14	1-57	.	.	.	27	4	0-23	7	0	0-62	.	.	.	26	4	1-23	12	8	0-58
VALLEY HOSP POMONA CA 91767	.	.	.	.	.	.	1	0	0-100	15	0	0-83	.	.	.	1	0	0-100	2	0	0-100	.	.	.	6	0	0-99
VALLEY HOSPITAL MEDICAL CE VAN NUYS CA 91405	9	22	4-59	16	31	14-59	29	3	1-24	17	0	0-97	72	8	2-14	63	8	3-18	9	0	0-97	73	3	2-14	48	0	0-17
VALLEY MEO CENTER FRESNO CA 93702	14	21	2-49	8	63	13-73	37	16	5-28	4	0	0-100	76	14	2-14	78	5	2-15	5	0	0-100	100	7	2-11	24	0	0-26
VALLEY MEMORIAL HOSP LIVERMORE CA 94550	10	20	8-63	14	29	13-61	44	0	2-20	2	0	0-100	113	7	2-11	29	0	1-24	8	0	0-78	71	1	1-13	60	0	0-13
VALLEY PARK MEDICAL CTR CANOGA PARK CA 91307	2	0	0-93	2	50	3-91	4	25	1-74	.	.	.	6	33	0-63	13	8	0-40	1	0	0-100	13	0	0-41	20	35	1-28
VALLEY PRESBYTERIAN HOSPIT VAN NUYS CA 91406	16	31	12-59	49	41	26-56	59	14	4-21	35	0	0-61	214	4	2-9	103	7	2-14	26	0	0-27	216	6	2-9	179	2	0-6
VAN NUYS COMMUNITY HOSPITA VAN NUYS CA 91401	6	33	2-66	4	50	6-80	12	17	2-44	1	0	0-100	23	9	1-27	22	14	1-29	4	0	0-100	10	0	0-47	17	6	0-44
VENTURA COUNTY MEO CTR VENTURA CA 93003	7	14	4-65	5	100	12-83	20	10	1-31	.	.	.	39	8	2-20	19	5	0-37	5	0	0-100	40	20	1-18	24	0	0-50
VERDUGO HILLS HOSP GLENDALE CA 91209	19	42	14-58	8	38	13-73	72	15	4-19	26	4	0-87	133	7	2-11	91	9	1-13	31	0	0-82	108	3	2-11	152	2	0-6
VICTOR VALLEY COMM HOSP VICTORVILLE CA 92392	11	18	5-56	7	43	12-75	30	10	3-27	2	0	0-100	81	4	2-13	72	3	1-14	2	50	0-100	111	5	2-10	27	4	0-24
VILLA VIEW COMMUNITY HOSP SAN DIEGO CA 92115	2	0	4-92	6	67	14-81	24	8	2-29	6	0	0-100	47	11	2-17	20	15	1-30	2	0	0-100	32	6	1-21	20	0	0-55
VISALIA COMMUNITY HOSP VISALIA CA 93277	7	14	8-71	9	56	13-70	14	7	1-38	8	0	0-95	53	2	1-15	13	15	1-40	8	0	0-80	75	0	2-13	24	0	0-41

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		High Risk Diagnostic Categories																							
		Overall			Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
WARRACK MEDICAL CENTER HOS SANTA ROSA CA 95405	CA-507*	729	8	8-16	62	13	11-35	35	29	13-43	26	12	8-40	42	17	14-40	11	45	16-69	25	8	11-47	62	11	11-33
WASHINGTON HDSP FREMONT CA 94538	CA-508*	1820	14	10-16	99	17	13-33	80	33	18-39	34	26	9-38	104	28	15-32	75	45	27-51	51	27	12-39	190	26	14-27
WASHINGTON HDSPITAL CULVER CITY CA 90230	CA-509	608	15	8-16	52	23	10-35	18	11	13-54	14	43	7-51	30	17	11-42	12	25	17-68	25	28	10-46	44	36	12-38
WATSONVILLE COMMUNITY HOSP WATSONVILLE CA 95076	CA-510	1126	11	9-17	90	12	13-34	43	44	15-41	51	12	8-31	49	20	13-37	44	39	25-54	32	22	8-38	126	17	16-32
WEST COVINA HDSP WEST COVINA CA 91790	CA-511	164	16	7-19	9	22	6-60	4	50	3-75	5	0	2-68	4	0	2-75	3	33	6-87	10	20	2-50	33	39	7-35
WEST SIDE COMM HOSP NEWMAN CA 95360	CA-512*	115	16	11-26	6	67	6-70	4	50	7-81	1	0	0-97	11	18	7-55	1	0	0-97	3	0	1-82	34	24	13-43
WEST SIDE DISTRICT HOSPITA TAFT CA 93268	CA-513*	144	17	10-23	6	67	14-81	8	50	8-65	6	17	1-63	13	0	8-53	5	60	9-80	10	50	5-56	24	8	8-41
WESTERN MEDICAL CENTER-SAN SANTA ANA CA 92705	CA-514	1836	15	9-16	142	31	18-36	65	34	18-41	39	28	8-35	101	26	15-33	70	43	27-51	54	19	11-37	129	31	14-30
WESTERN MEDICAL CTR - ANAH ANAHEIM CA 92803	CA-515	552	10	6-14	5	40	4-73	20	55	16-56	4	50	1-75	12	25	6-51	29	66	21-55	11	0	4-52	26	15	7-39
WESTERN PARK HDSPITAL ME01 LOS ANGELES CA 90018	CA-516*	716	13	9-16	24	21	13-49	22	27	12-48	17	18	3-39	34	15	11-40	14	57	22-70	34	15	8-37	61	18	12-34
WESTLAKE COMMUNITY HOSPITA WESTLAKE VILLAGE CA 91361	CA-517	479	9	8-16	38	32	16-46	12	50	12-61	14	14	3-43	21	14	11-47	7	0	9-70	18	17	6-44	41	7	8-33
WESTSIDE HDSPITAL LOS ANGELES CA 90036	CA-518	645	16	10-18	22	36	10-46	28	46	18-52	15	7	3-43	55	20	14-37	23	74	28-68	25	20	7-40	47	28	14-40
WESTWORLD COMM HLTHCARE IN NEEDLES CA 92363	CA-519*	154	8	5-17	7	29	4-63	10	20	8-59	3	33	1-81	10	0	3-51	4	25	5-80	3	0	1-82	17	24	4-40
WHEELER HDSP GILROY CA 95020	CA-520*	552	12	10-18	31	26	11-43	19	53	14-54	11	9	2-48	33	21	12-41	32	41	22-56	22	5	7-43	57	18	13-36
WHITE MEMORIAL MEDICAL CEN LOS ANGELES CA 90033	CA-521	1469	11	10-16	104	26	18-38	47	21	16-42	24	8	7-40	103	16	16-33	49	49	30-58	42	7	6-32	100	18	13-31
WHITTIER HDSP WHITTIER CA 90605	CA-522	1167	15	10-17	63	21	14-38	35	34	17-47	35	17	9-37	76	25	15-35	27	59	24-61	43	28	8-35	110	30	14-32
WOODLAND MEM HOSP WOODLAND CA 95695	CA-523	1315	13	9-16	131	21	12-30	59	29	17-41	31	13	9-39	60	18	13-34	46	37	26-55	26	8	9-42	106	26	13-30
WOODRUFF COMMUNITY HDSP IN LONG BEACH CA 90808	CA-524*	448	14	8-17	29	14	14-47	11	18	11-62	10	30	4-54	19	26	10-48	8	13	13-72	3	0	1-82	67	31	12-34
YDLO GEN HOSP WOODLAND CA 95695	CA-525*	146	10	5-16	7	43	10-72	3	0	2-82	1	0	0-99	2	100	0-91	4	50	4-78	6	0	4-67	13	38	8-54

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

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HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Dphthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
WARRACK MEDICAL CENTER HDS SANTA ROSA CA 95405	11	18	10-63	5	20	11-81	24	4	3-30	14	0	0-98	60	3	1-14	50	2	1-17	22	0	0-98	34	0	1-19	48	2	0-14
WASHINGTON HOSP FREMONT CA 94538	20	15	8-50	36	31	21-54	62	8	5-22	9	0	0-98	171	6	3-11	59	5	2-17	12	0	0-98	195	3	2-9	90	3	0-8
WASHINGTON HOSPITAL CULVER CITY CA 90230	2	0	0-92	14	50	19-68	19	11	1-32	4	0	0-100	61	3	1-14	44	7	1-19	8	0	0-99	26	4	1-24	39	3	0-17
WATSONVILLE COMMUNITY HDSP WATSONVILLE CA 95076	9	0	8-66	8	38	9-69	38	5	3-24	4	0	0-100	91	3	1-12	80	0	1-14	13	0	0-99	97	1	2-11	53	0	0-14
WEST COVINA HDSP WEST COVINA CA 91790	7	43	5-66	3	33	2-82	2	0	0-92	.	.	.	15	0	0-39	5	20	0-73	3	0	0-100	12	0	1-41	9	0	0-98
WEST SIDE COMM HOSP NEWMAN CA 95360	2	0	1-90	1	0	1-97	.	.	.	.	.	.	12	0	1-41	2	0	0-93	.	.	.	14	0	0-39	3	0	0-100
WEST SIDE DISTRICT HDSPITA TAFT CA 93268	1	0	0-99	1	100	2-98	.	.	.	.	.	.	14	7	0-37	2	0	0-95	1	0	0-100	21	10	0-27	2	0	0-100
WESTERN MEDICAL CENTER-SAN SANTA ANA CA 92705	19	26	9-53	29	31	21-57	60	8	3-19	86	0	0-11	124	13	3-13	80	4	1-14	16	0	0-91	243	5	2-8	79	4	0-10
WESTERN MEDICAL CTR - ANAH ANAHEIM CA 92803	1	0	0-100	4	50	10-86	5	0	0-78	.	.	.	17	18	1-34	5	0	0-74	.	.	.	193	3	3-9	21	5	0-52
WESTERN PARK HDSPITAL MEDI LOS ANGELES CA 90018	9	11	7-64	21	71	28-70	13	8	1-40	1	100	0-100	62	6	1-14	61	5	2-16	3	0	0-100	54	7	1-15	44	0	0-17
WESTLAKE COMMUNITY HDSPITA WESTLAKE VILLAGE CA 91361	7	0	2-63	5	60	11-81	25	0	2-27	4	0	0-100	41	5	1-18	20	5	0-33	3	0	0-100	46	4	2-19	41	5	0-17
WESTSIDE HDSPITAL LOS ANGELES CA 90036	7	29	10-73	10	30	14-70	23	9	3-31	2	0	0-100	32	9	2-23	46	4	2-19	5	20	0-95	47	6	1-17	34	0	0-25
WESTWORLD COMM HLTHCARE IN NEEDLES CA 92363	2	0	1-90	.	.	.	.	.	.	.	.	.	18	0	0-31	4	0	0-76	2	0	0-100	25	0	0-24	1	0	0-100
WHEELER HDSP GILRDY CA 95020	3	67	4-85	5	0	7-76	13	0	2-42	.	.	.	61	5	2-15	29	3	1-24	3	0	0-100	74	3	1-12	18	0	0-46
WHITE MEMORIAL MEDICAL CEN LOS ANGELES CA 90033	18	11	11-56	23	43	20-60	36	8	4-26	55	0	0-24	102	6	4-16	87	7	2-15	11	0	0-65	183	5	2-9	53	0	0-13
WHITTIER HDSP WHITTIER CA 90605	12	17	5-54	26	31	19-57	39	5	3-25	1	0	0-100	129	6	3-12	75	17	4-19	6	0	0-100	101	4	2-12	69	1	0-10
WOODLAND MEM HOSP WOODLAND CA 95695	8	25	10-70	15	53	13-60	36	8	3-25	4	25	0-100	126	2	2-11	76	7	1-14	16	0	0-73	101	6	2-11	72	3	0-10
WOODRUFF COMMUNITY HDSP IN LDNG BEACH CA 90808	6	17	3-68	4	25	5-80	13	15	2-42	1	0	0-100	50	12	2-17	37	5	2-22	7	0	0-85	32	0	1-21	33	3	0-27
YOLD GEN HDSP WOODLAND CA 95695	2	50	1-90	.	.	.	1	0	0-99	.	.	.	8	13	0-70	4	0	0-78	.	.	.	8	0	0-61	6	0	0-100

*Written Comments Not Submitted.

Memorandum



To : William L. Roper, MD
Administrator

Date : October 1, 1987

File No.:

From : Agnews Developmental Center—San Jose

Mary Antone, CRO
Mary Antone, ART
Client Records Officer

Subject : Mortality Rates Memo

Thank you for your memo dated September 21, 1987 regarding mortality information about all short term acute hospitals which treated Medicare patients in 1986.

The information that you sent us specific to Agnews mortality rate is accurate.

If I can be of further assistance, please feel free to contact me. Thank you.

Alameda Hospital

October 23, 1987

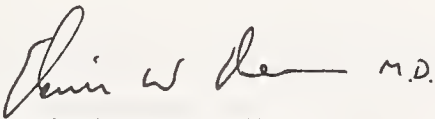
William L. Roper, M.D., Administrator
Department of Health & Human Services
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

Enclosed is Alameda Hospital's comments on the HCFA mortality data for 1986. Should additional information or clarification be needed, please feel free to contact me.

Sincerely,


William Dal Cielo
Administrator


Denis W. Drew, M.D.
President, Medical Staff

Alameda Hospital

October 1988

COMMENTS ON THE HCFA MORTALITY DATA

Year 1986

Data Verification

The data used by HCFA indicate that of a total of 1288 Medicare patients admitted to Alameda Hospital, 202 died within 30 days of admission. Of these, 139 died while still a patient of the hospital, while 63 died after discharge. Our own records indicate that 2094 Medicare admissions occurred in 1986. Presumably the discrepancy reflects multiple admissions of individual beneficiaries to the hospital. We have no way of verifying whether the HCFA number of 1288 is correct. Our own records indicate that 160 Medicare patients died within 30 days of admission while still an inpatient. It is impossible to verify the percentage of patients who died after discharge since information concerning death after discharge is not included in the patient's medical record.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

Interpretive Remarks

In one of the diagnostic categories, pulmonary disease (which is classified by HCFA as high risk), the hospital's actual mortality rate falls outside of the range of the predicted mortality rate. Several factors may account for this difference.

Unique Services Resulting in Higher than Average Mortality

Alameda Hospital, a non-profit community hospital, offers a range of high quality acute care services primarily to the residents of the island of Alameda. Multiple Skilled and Intermediate Nursing Facilities exist on the island and in nearby communities. In 1986, 11% of Alameda Hospital's patients were admitted from a Skilled Nursing Facility and 15% were transferred to a similar facility at discharge. While the average percentage of Medicare patients in all hospitals in the East Bay Hospital Conference is 29.4%, the percentage of Medicare patients admitted to Alameda Hospital is 50.5%. Additionally, the percentage of patients over the age of 75 is high at Alameda, reaching 30.6%; other East Bay Hospital Conference facilities record an average percentage of 14.5%.

Results of Preliminary Medicare Record Review

In the category of pulmonary disease, hospital records indicate that 267 patients were treated during 1986 while the HCFA Mortality Data included only 135 patients. Presumably, part of the discrepancy can be attributed to the fact that the study uses one patient/one admission for the year. Another reason can be explained by the fact that some diagnoses commonly regarded as pulmonary diagnoses were excluded from the study.

All records of the patients who expired either at Alameda Hospital or within 30 days of admission in the pulmonary disease category were identified. All deaths were verified. Careful review of the records revealed very elderly patients, average age of 81 years, with multiple chronic medical problems, who had been cared for at home or at a nearby Skilled Nursing Facility and only admitted to the hospital when close to death. The length of stay was very short for most of these patients and for those patients who were discharged alive but expired within 30 days, all were transferred to a Skilled Nursing Facility. All the factors combined resulted in a higher than predicted mortality rate within this particular category.



ALEXIAN BROTHERS
Hospital

October 27, 1987

Dr. William Roper
Healthcare Finance Administration
Hospital Mortality Data
6900 Security Blvd.
Madison East Building, Room 202
Baltimore, MD 21207

Dr. Roper:

Thank you for giving Alexian Brothers Hospital the opportunity to append comments to the January - December 1986 HCFA Hospital Mortality Data Release for our hospital.

The new format using the simplified diagnosis groupings of High Risk and Low Risk conditions is a change from the previous methods in the past three reports we have received from CMRI. We are, therefore, unable to compare the information to past reports and come to any conclusions. We noted that our Mortality Rate of 14% reflects an approximate doubling of the previous rate because the data includes patients who died within 30 days of discharge; prior data was not categorized in this manner.

It would be our recommendation, that in the future, both the Hospital Death Rate and the Death Rate within 30 days of discharge be included in the statistics. Another suggestion would be to rank the death rate from highest to lowest.

The data released by HCFA indicates that Alexian Brothers Hospital falls within the range of predicted mortality rates in all categories.

Mortality statistics collected by HCFA are indicators. Though we appreciate the opportunity to evaluate this data, we question the validity of it and encourage you to gather data with an emphasis on quality and appropriateness of care.

Thank you for the opportunity to respond. We hope that our comments are cause for reflection and further refinement of the data will continue.

Sincerely,

Dean Grant
Dean Grant, President
Alexian Brothers Hospital

DG/lg



Alta Bates
Hospital

3001 Colby Street
Berkeley, CA
94705

Telephone
415/540-0337

October 22, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, DC 20201

Dear Dr. Roper:

On behalf of the Board of Trustees, the administration and the medical staff of Alta Bates Hospital, thank you for the opportunity to provide a response to the mortality statistics for calendar year 1986 compiled by the Department of Health and Human Services. We are pleased that the data indicate that the mortality rates experienced at Alta Bates fall within the predicted range in each of the diagnostic categories.

Alta Bates Hospital is a 317-bed acute care facility, whose specialties include women and infants services, cardiovascular services including open heart surgery, oncology services including hospice, an in-house skilled nursing facility, and regional services in burn care, high-risk obstetrics, and adult bone marrow transplantation.

The hospital's medical staff and administration closely monitor the quality of patient care through several mechanisms, but primarily through an ongoing Quality Assurance Program, which, as one of its responsibilities, reviews all deaths to assess medical management and overall care. Individual clinical departments of the medical staff are also responsible for monitoring and evaluating patient care provided in each of their departments. Alta Bates has a Perinatal Mortality and Morbidity Subcommittee which looks at every stillbirth, neonatal death and transfer. In addition, the medical staff conducts regular peer review activities.

The mortality data was reviewed by the physician chairman of the Utilization Review Committee, the executive director of utilization and case management, and the directors of medical records, quality assurance, and patient care management services. In reviewing the data, we would like to note the following:

- 1) Severe Acute Heart Disease (HS) - We have no records of admission for two of the patients listed in this diagnostic category. The number of deaths should total 64, not 66.
- 2) Pulmonary Disease (PN) - We have no record of admission for one of the patients listed in this diagnostic category. The number of deaths should total 172, not 173.

As we mentioned earlier, the data show that the mortality rates experienced at Alta Bates fall within the predicted range calculated by the Department for this institution in each of the diagnostic categories.

We support the efforts of the Department to inform the public concerning health care delivery, and we believe that the release of this report is a step in that direction. We understand that there are limitations on using this data and determining the overall quality of care at a facility solely by this report would be inappropriate. We look forward to further enhancements which will help the public better understand the complexities of measuring quality and, in turn, help them become better consumers of health care.

Dr. William L. Roper
October 22, 1987
Page 2

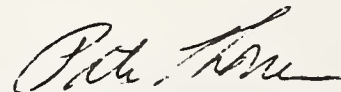
The Board, administration and medical staff of Alta Bates will support this effort as well as continue to regularly monitor patient care to ensure quality care is provided to all patients at Alta Bates.

If there are any questions, please direct them to the Public Affairs Department, (415) 428-4545.

Sincerely,



Eleanor G. Claus
Executive Vice President



Pate Thomson, M.D.
President, Medical Staff

0384G



October 26, 1987

William Roper, M.D., Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

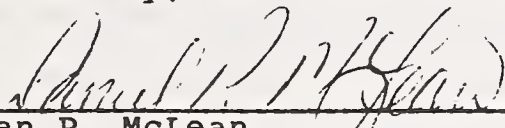
Thank you for this opportunity to respond to the 1986 Medicare Mortality Data. The Mortality Data to be released in December of 1987 has been reviewed by our Hospital Administration, Chief of Staff, the Chairmen of the Quality Assurance and Utilization Review Committees, as well as by the Utilization Review and Quality Assurance Coordinators. Our Director of Medical Records has validated that with minor exceptions, the data is accurate.

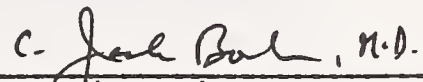
Mortality review is an ongoing process by the Medical Staff of Alvarado Hospital Medical Center. Each death is screened for medical management of the case and overall care. This is an integral part of monitoring of the health care delivery system at our hospital.

We are pleased, again, to see that Alvarado Hospital falls within the low or mid range of all the ranges with one exception, cancer. Alvarado is 2% over the top of this range. This can be attributed to the fact that Alvarado has the exclusive San Diego contract with San Diego Hospice, the facility for the terminally ill. These patients essentially come to Alvarado Hospital during the last phase of their illness, to die.

We feel that the statistics are reflective of the high quality of care rendered by the Medical Staff and Support Services at Alvarado Hospital Medical Center.

Sincerely,


Dan P. McLean
Chief Executive Officer


C. Jack Bark, M.D.
Chief of Staff

DM:plb



4747 Engle Road
Carmichael, CA
95608

October 27, 1987

Telephone
916
486-3211

Mr. Harvey Brooks
Health Care Financing Authority
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Mr. Brooks:

American River Hospital appreciates the opportunity to provide comments on HCFA's release of mortality data on Medicare patients treated at American River Hospital in 1986.

The data supplied by HCFA has been reviewed by the hospital's Quality Assurance Committee, Medical Director, Medical Records, Medical Staff Executive Committee and Administrative staff.

The hospital's overall mortality rate, as well as the rate in 15 of HCFA's 16 categories, was within HCFA's predicted range for the hospital's Medicare patient population.

The hospital marginally exceeded its range in only one category: deaths from Pulmonary Disease. The hospital's mortality rate was 29% and HCFA's predicted range was 14 to 26 percent. Our review of the mortalities in this category revealed two significant measurements of severity of illness which were not factors in HCFA's computation of predicted mortality ranges.

- 1) 80 percent of the pulmonary disease mortalities were patients who were admitted with or early in their hospital stay requested a "no code" status. In other words, the patient or family members requested no resuscitation attempts or heroic measures be made on the patient's behalf due to the terminal nature of the illness.
- 2) Our review also indicated a significant number of patients who were transferred from skilled nursing facilities for acute care treatment prior to the terminal event of their chronic illness.

Our clinical review of each case revealed that the level and quality of care rendered each individual patient was appropriate.

Member of the
Alta Bates
Health System
Not-for-profit

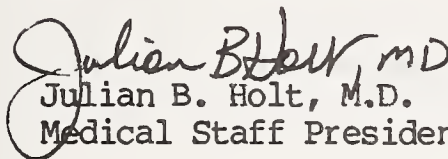
H. Brooks
Page 2

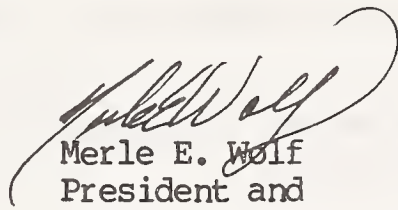
American River Hospital management and medical staff will continue to review all mortality cases for appropriateness and quality of care. Our mortality review is an ongoing process of our Quality Assurance program and is an integral part of our internal monitoring of quality of care rendered at the hospital.

Finally, we agree with HCFA Administrator William Roper's comment that the information contained in this report should not be used to make judgments about the quality of care in an individual hospital or to make comparisons among hospitals. American River Hospital continues to believe that the public benefits from information which will help them make more informed decisions about their health care. We encourage the efforts of AHA and the Joint Commission on the Accreditation of Hospitals to determine more meaningful methods of evaluating quality of care.

Thank you for the opportunity to present this response. If you have questions about our response, please do not hesitate to call.

Sincerely,

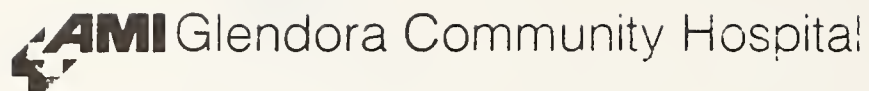

Julian B. Holt, M.D.
Medical Staff President


Merle E. Wolf
President and
Chief Executive Officer

JBH/MEW:CB/mlb

cc:

Paul Gerard, M.D., Chairman, Quality Assurance Committee
Edwin Gipson, Chairman, Board of Trustees
David Seeley, Alta Bates Corporation
Richard Armstrong, M.D., Medical Director, Utilization Management
Carol Benham, Director of Communications
Ruth Colavecchio, Vice President, Resource Management
M. Jane Thomas, Hospital Council of Northern California



October 27, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Dr. William Roper:

Thank you for the opportunity to provide input on the mortality statistics for 1986.

The Medical Staff at Glendora Community Hospital conducts an intensive review of the medical record of every patient who expires at this facility regarding medical management and overall care. Mortality review is an on-going process of the Quality Assurance program and peer review activities are an integral part of the monitoring of the healthcare delivery system at this hospital.

Our overall percentage of deaths is less than the range of predicted mortality rates.

The following summarizes our findings of the two categories that are over the predicted mortality rates.

1. CANCER

The predicted percentage of deaths in this category was 14-53%. Ours was 59%. It should be noted that:

The average age of the patients was 74 years old. This includes one patient, age 40, with a diagnosis of Metastatic Lymphoma as well as 10 years of history of advanced end stage renal disease.

2. SEVERE ACUTE HEART DISEASE

The predicted percentage of deaths in this category was 19-67%. Ours was 71%. It should be noted that:

- A. The number of deaths in this category reflects one of the major service centers of our facility - Nephrology.
- B. Of all the patients diagnosed as having acute heart disease, over 50% had a comorbidity of advanced end stage renal disease.

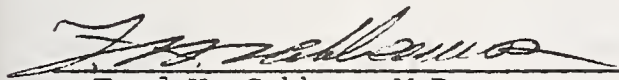
2. SEVERE ACUTE HEART DISEASE

- C. This group was not coded due to severity of the comorbidity diagnosis of terminal end stage renal disease and/or upon request of the patient and family members.

Thank you for the opportunity to present this response. If you have additional questions, please do not hesitate to call.

Sincerely,


Mr. Michael Ramsey
Chief Executive Officer


Fred H. Sahhar, M.D.
DRG Physician Advisor

October 28, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 91207

Dear Dr. Roper:

Thank you for this opportunity to respond to HCFA's release of data on hospital mortality rates for Medical Center of North Hollywood. It should be noted that the Medical Staff of Medical Center of North Hollywood has an extensive review process of all hospital deaths. This process is comprised of experts from a multitude of medical and surgical specialties. It is in this fashion that quality of care can be monitored on an on-going basis.

The Medical Center's over-all mortality rate is consistent with the predicted mortality rates. However, we exceed the predicted mortality rate in four diagnostic categories. These are: cerebrovascular accidents, severe acute heart disease, pulmonary disease and renal disease. These four categories are all in the high risk diagnosis.

Of note, 90% of the patients who expired in these four categories were over 79 years of age. These patients with advanced ages frequently have multiple system failure that increase their mortality rate.

We would ask that this information be placed on file as we are most proud of the quality of patient care at Medical Center of North Hollywood.

Sincerely,


Ira M. Horwitz, M.D.
Medical Director, Utilization Review


Steven C. Bjelich
Executive Vice President

October 19, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Sir:

Thank you for the opportunity to provide input on the mortality statistics for Medicare patients for 1986.

As you suggested, we have reviewed the individual patient information to verify actual admissions. The only discrepancy found was for the following patient:

Patient ID Number: [REDACTED]
Surname: [REDACTED]
Admission Date: 6-27-86
Discharge Date: 6-27-86

We could find no record of this patient being admitted. It should be noted, however, that the next patient on the list had the identical information listed and we were able to verify this patient's admission. (See attached.)

We would like to include the following comments as part of the December release of the mortality data:

AMI Sierra Vista Regional Medical Center and its medical staff perform ongoing review of mortality cases for appropriateness and quality of care.

The Quality Assurance Committee has reviewed the mortality data for our hospital and was pleased to see that the actual mortality rate was within the lower end of the range of predicted mortality rates for most categories and below the range for two of the categories. In no category was the actual rate higher than the predicted rate.

The statistics for the category of "CE - Cancer" indicate that the actual mortality rate is 30%, which is at the upper range of the predicted mortality rate, but well within the range. It should be noted that AMI Sierra Vista Regional Medical Center has been designated a Rural Referral Center for Medicare patients and has the only Radiation Oncology Service in the county. In addition, most of the oncologists treat their patients at this hospital and frequently, the patients are diagnosed during a previous hospitalization and are admitted subsequently for terminal care.

1010 Murray Avenue P.O. Box 100000 Dallas, Texas 75210-0000 (934) 613-6777 805-541-1100

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.



The statistics for the category "TR - Severe Trauma" indicate that the actual mortality rate is 4%, which is at the lower end of the predicted range of 3 to 20%. These are favorable statistics since AMI Sierra Vista Regional Medical Center is an Emergency Medical Services Agency Base Station and the hospital receives most of the neuro cases in the County.

The hospital supports the principle of communicating appropriate and meaningful quality of care information to consumers and welcomes the opportunity to discuss the quality of care provided.

Thank you for the opportunity to present this response.

Sincerely,

A handwritten signature in dark ink, appearing to read "Glenn D. Carlson", is written over the typed name.

Glenn D. Carlson
Executive Director

GDC:vt

October 20, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Ms. Shea,

In response to the notification of intent to release the January through December 1986 mortality data from AMI Valley Medical Center, the following comments should be attached:

AMI Valley Medical Center, located in El Cajon, CA, is situated in a densely populated area of elderly, retired citizens. In addition, there are 11 to 12 nursing homes for which we are the closest hospital, and 26 nursing homes are within a 10 to 15 mile radius. A large percentage of our admissions comes from these facilities.

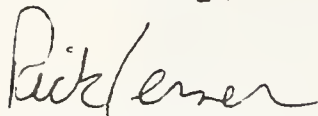
Our death rates are higher in the disease entities common to elderly nursing home patients, such as respiratory infections and sepsis. In an intensive review of deaths due to sepsis, all patients were noted to have been made "no codes" at the request of the patient or his family. Thirty-two percent of our deaths occurred within 48 hours of admission, and many of these deaths are considered to be inevitable.

The average age of our Medicare patients reflected in these statistics is 80.6. Of these 249 deaths, 87 (35%) were more than 85 years of age.

A comprehensive ongoing review of all mortalities occurring in this facility has always been a policy of our medical staff. These medical records are reviewed and discussed by the appropriate medical staff committees. There is also concurrent review performed on all patients for appropriateness and quality of their medical care. Our medical staff believes that one of its functions is to monitor the quality of care on an ongoing basis, not just when such data is released.

Thank you for the opportunity to comment on this data release.

Sincerely,

A handwritten signature in cursive script, appearing to read "Rick Lerner".

Rick Lerner
Acting Executive Director

RL: ff
Attachments

October 23, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Care Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, MD 21206

Dear Dr. Roper:

We appreciate the information provided by HCFA and the opportunity to provide comment. Our actual mortality rates are within the range of predicted mortality rates for all categories.

Under the auspices of our Medical Staff Quality Assurance Program, mortality cases are regularly reviewed and rates are monitored on an ongoing basis. This activity and the results and findings are a valuable component of the quality assurance process because they enable identification of opportunities to improve care, based on in depth peer review.

We would, however, caution others in using simple rates for judging the quality of care provided by different facilities.

Sincerely,



Ann Klein
Executive Director

AK:bw

(714) 827-6700



Anaheim General Hospital

Your Community Healthcare Specialists

3350 West Ball Road • Anaheim, California 92804

October 21, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Gentlemen:

The data used by HCFA indicate that a total of 74 Medicare patients admitted to Anaheim General Hospital died within 30 days of admission. Of these, 57 died while still a patient of the hospital, while 17 died after discharge. Our own records indicate that one of those 17 was actually an inpatient at this hospital when he expired.

A review of the actual mortality rates indicates Anaheim General Hospital's actual mortality rate for severe acute heart disease falls outside the range of the predicted mortality rate. One explanation for this is the fact that HCFA shows 10 cases falling into that category, but only identifies eight beneficiaries. Of those eight patients who died, three had families who specifically requested no heroic measures be undertaken by the hospital to keep the patients alive. Further, all eight were admitted through the Emergency Room either in cardiac arrest or having suffered an acute myocardial infarction. All eight had severe long-term cardiovascular disease as well as other complicating factors such as, extension of the myocardial infarction, chronic obstructive pulmonary disease, cardiogenic shock, hypertensive heart disease, chronic renal failure, various life-threatening cardiac arrhythmias, end stage lung fibrosis, congestive heart failure, pneumonia, septicemia, respiratory arrest and hypoxic encephalopathy.

We wish to inform you that all mortality cases are reviewed by the Medical Staff as part of the hospital's Quality Assurance Program to insure all mortalities are evaluated for the quality of the patient care provided. This critical analysis insures corrective actions are taken where needed and assists in preventing future recurrences of adverse care. Please be assured all those cases mentioned above were scrutinized and the care provided by the Medical Staff and hospital staff at Anaheim General Hospital was above reproach.

Yours truly,


Brad H. Jeffrey
Chief Executive Officer

An Affiliate of Jupiter Hospital Corporation



October 27, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

To Whom It May Concern:

Enclosed you will find the following information: 1) Verification of 1986 HCFA Mortality Report 2) Response to be attached to 1986 HCFA Mortality Report to be released to the public sometime in the month of December.

Sincerely,

A handwritten signature in dark ink, appearing to read "Robert Sloane", written over a horizontal line.

Robert Sloane
President/Chief Executive Officer



ANAHEIM
MEMORIAL
HOSPITAL

October 27, 1987

To Whom It May Concern:

In reviewing the 1986 HCFA Mortality Report, the following discrepancies were found in the data:

- 1) p. 3, line 17, [REDACTED] etc. same as
p. 3, line 18, [REDACTED] etc.

Patient's demo. data (HIC #, age, sex, diagnostic category, date of adm., dx, and death, principal dx. and principal procedure) identical to patient listed directly below.

Error: no patient by the name of [REDACTED] was found in our hospital database.

- 2) p. 6, line 1, [REDACTED] Name: [REDACTED] diagnostic category: UN, age: 094, sex: F, date of adm: 7/11/86, date of disch: 7/13/86, date of death: 7/13/86, principal dx 435.9. Patient was discharged alive from our facility and neither the attending MD, nor the O.C. Recorder's office has any documentation of the patients expiration. (The attending MD has subsequently lost the patient to follow up.)

- 3) The following is an error listing, by category, of discrepancies of pt. data that was found in verifying the 1986 HCFA Mortality:

HIC #	Name	Dx	age	sex	Date Death		in-pt. death	post-hosp death
					inc.	corr.		
[REDACTED]	[REDACTED]	PN	85	F	3/12/86	3/13/86	yes	
[REDACTED]	[REDACTED]	HL	72	M	12/31/86	12/16/86	yes	
[REDACTED]	[REDACTED]	HL	96	F	7/15/86	7/14/86	yes	
[REDACTED]	[REDACTED]	ME	71	F	1/05/87	1/04/87		yes

Please review the aforementioned discrepancies and feel free to contact me if you have any questions on our data analysis or verification.

Sincerely,

Jean Rico, ART
QA/DRG Manager, (714) 999-6054



**ANAHEIM MEMORIAL HOSPITAL'S RESPONSE TO THE
1986 HCFA MORTALITY REPORT FOR CALENDAR 1986**

Anaheim Memorial Hospital is a 240 bed acute care facility, whose case mix includes many patients with major medical and surgical illnesses. We are a full service medical center offering care in specialty areas of oncology, cardiology, cardiovascular surgery, major orthopedic services, pulmonary medicine, as well as general medical/surgical services.

The hospital specific mortality data reported by HCFA has been verified and reviewed by: the hospital administration, Chief of Medical Staff, Physician Chairmen of the Utilization Review and Quality Assurance Committees, QA/DRG Manager and the Director of Medical Records.

The overall mortality rate, as well as the diagnostic category specific mortality rates, are all within the range of predicted mortality rates.

The Medical Staff at Anaheim Memorial Hospital conducts an intensive review of the medical record of every patient who expires at this facility regarding medical management and overall quality of care. Mortality review is an on-going process of the Quality Assurance Program and peer review activities are an integral part of the monitoring of the healthcare delivery system at this facility.

Said quality review activities are performed on an individual case basis and not only when statistics such as the HCFA mortality data are released.

Thank you for the opportunity to present this response.

General Information: Monica Statz, Communications Manager at (714) 999-3852.

Specific Questions Regarding Mortality Statistics: Jean Rico, ART, Quality Assurance Manager at (714) 999-6054 or Barbara Pinkowitz, RRA, Director of Medical Information Services at (714) 999-6039.

Sincerely,

A handwritten signature in dark ink, appearing to read "Robert Sloane", is written over a horizontal line.

Robert Sloane
President/Chief Executive Officer

Antelope Valley Hospital Medical Center

1600 West Avenue J, Lancaster, California 93534 (805) 949-5000

October 26, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Gentlemen:

Thank you for the opportunity to respond to the Health Care Financing Administration (HCFA) mortality information.

The data collected by HCFA indicates that the mortality rate for all Medicare patients who expired at Antelope Valley Hospital Medical Center (AVHMC) and/or within 30 days of their last hospital admission are within the "range of predicted mortality rates".

Every death at AVHMC is reviewed by the appropriate Medical Staff Service Committee and its Chairman. Additionally, a monthly report is submitted to the Quality Assurance Committee and the Board of Directors. There are many variables that must be considered in evaluating why patients expire; mortality rates do not indicate why patients die.

The information reviewed indicates that primary diagnostic codes only indicate why patients are admitted to the acute care setting. These codes do not take into account any other pre-existing conditions or that multiple problems may have been present when the patient was admitted to the facility.

All cases reviewed in the high risk diagnostic categories revealed that these patients had either pre-existing health care problems and/or multiple health care problems upon admission. Another issue that analysis of the data revealed is that many patients or their families elected not to receive cardiopulmonary resuscitation if the prognosis was poor or their condition deteriorated to the point of requiring life support treatment. At AVHMC, if the patient's wish (or family if the patient is not able to choose) is that no cardiopulmonary resuscitation be instituted, the wish is honored. However, this does not mean that treatment is not rendered. Antibiotic therapy, hydration, treatment of hypotension and arrhythmias, surgical intervention, and all other measures needed to treat the patient, with the exception of intubation and cardiac compressions, are rendered. Review of the high risk categories which included "all other conditions" revealed that 30 patients requested "no CPR". All cases reviewed indicated appropriate treatment was instituted short of intubation and cardiac compressions.

A Facility of the Antelope Valley Hospital District

Board of Directors: Harvey A. Birsner, M.D., Ralph R. Holmes, M.D., Clarence W. Kelly, Frances C. Kuhn, Michael G. Schafer

Approved by Joint Commission on Accreditation of Hospitals

The focus of our review was directed to low risk diagnostic categories. The cases fell into the following categories:

1. Gastrointestinal Disease. Number of Cases - 7.
One patient died outside AVHMC at a skilled nursing facility. All patients in this category had concurrent co-morbid conditions such as cirrhosis, respiratory and cardiac insufficiency, and end stage renal disease.
2. Urologic Disease. Number of Cases - 4.
Two patients died outside AVHMC. One 88 year old was admitted with urologic disorder and aspiration pneumonia. The patient improved and was transferred to a convalescent facility. The second patient was an end stage renal disease patient. Information from the attending physician indicated the patient was non-compliant and brought to the ER in full arrest after failing to keep regularly scheduled outpatient dialysis treatment appointments. The other two patients died at AVHMC. One patient with a urinary tract infection was also treated for diabetes, stroke, and respiratory insufficiency. The fourth patient had cancer of the uterus. Patient refused continued treatment and requested consultation with a home health agency regarding hospice care and expired before returning home.
3. Low Risk Heart Disease. Number of Cases - 3.
Two of these patients expired outside of AVHMC. One patient had uncontrolled hypertension as well as multiple infarct dementia. The prognosis was poor upon admission and the family requested placement in a long term facility. The second patient was admitted for chest pain. All studies were negative. The patient requested discharge, was apprised of the risks, and left the facility. The third patient in this category was admitted with heart disease, severe electrolyte imbalance, and blood sugars well over 1000 mgm/dl. The patient arrested and was not able to be resuscitated successfully.
4. Orthopedic Conditions. Number of Cases - 1.
This 89 year old died during hospitalization. The patient presented with a fractured arm but was noted in the ER to have urinary tract infection and hypokalemia. The patient was treated with antibiotics and the arm immobilized. The patient was also treated for congestive heart failure, but went on to expire due to heart and pulmonary problems.

Indicators have been established to review each death which occurs, either as an inpatient or in the Emergency Department. Indicators include:

1. Treatment Management
2. Complexity of Case

October 22, 1987

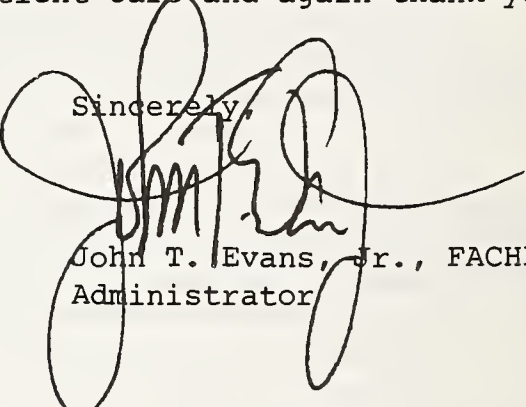
Page 3

3. Resuscitation Measures
4. Surgical Procedures
5. Prognosis on Admission
6. Hospital incurred incident
7. Death as an inpatient or in the Emergency Department occurring within 30 days of a previous admission

Mortality review is only one component of measuring quality of patient care in our on-going Quality Assurance Program.

The predicted ranges established by HCFA have assisted our Board of Directors, Medical Staff, and Administration in enhancing our mortality review. We are committed to improving patient care and again thank you for the opportunity to respond.

Sincerely,

A large, stylized handwritten signature in black ink, appearing to read 'J. T. Evans, Jr.', is written over the typed name and title.

John T. Evans, Jr., FACHE
Administrator

bs/lbh:wcm

October 21, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Sirs:

The mortality data for AMI Arroyo Grande Community Hospital has been carefully reviewed. We find the data to be accurate and we feel it reflects well on the hospital. We would like to highlight some relevant information we feel will help those reviewing the data.

AMI Arroyo Grande Community Hospital is a 79 bed acute care facility whose case mix includes many patients with major medical and surgical illnesses. The acuity of patients tends to be high. In 1986, 61% of all patients were over age 65. This data relates only to this group of patients as non-Medicare patients are not included in these figures.

A persons medical history, general physical condition and age are major factors which will impact their recovery. AMI Arroyo Grande Community Hospital is located in and serves an area with a high concentration of elderly. Consequently, the hospital's patients have a high average age and tend to be in poorer physical condition than a younger population of patients. Older patients have more complications and their problems will be more difficult to treat. Given these factors one might hypothesize that AMI Arroyo Grande Community Hospital would have a higher than average mortality rate. The HCFA data shows that contrary to that assumption, the hospital's mortality rates are well WITHIN the predicted range.

The hospital fell within the "Range of predicted mortality rates" in every category except renal disease where there were no deaths. Our overall death rate was 13% which is the very middle of the predicted range.

Because of the age of our patients (average age at death is 75 with patients also in the 80's or 90's), the terminal event most often involves one of five areas: Cancer, CVA, chronic heart disease, acute heart disease or pulmonary diseases. This fact is reflected in the data for our hospital. We had no deaths in the low risk areas of orthopedics, gynecology, ophthalmology, and renal disease. We feel our close monitoring of the care provided to our patients has been effective in keeping our death rate well within HCFA's predicted ranges.

Page 2

Each patient's care is monitored by established screening criteria which are used as quality checks to identify any areas that might present a possible problem. Any area not meeting the quality check is reviewed by a committee of the medical staff. In addition, all deaths in the hospital are reviewed by a committee of the medical staff. We believe this intensive monitoring technique assures the best medical care possible for our patients.

We are confident of the medical care provided by our hospital. The hospital will be glad to respond to any specific questions or provide further data to those requesting it. You may contact Richard N. Woolslayer, Executive Director, at 805/489-4261, Ext. 250. Thank you for the opportunity to present this response.

Sincerely,

Dick Woolslayer
Richard N. Woolslayer
Executive Director



AUBURN FAITH
COMMUNITY
HOSPITAL

11815 Education St.
P.O. Box 8992
Auburn, California 95604
(916) 885-7201

October 21, 1987

Health Care Financing Administrator
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Re: HCFA Mortality Data Release - Auburn Faith Community Hospital

Gentlemen:

After an analysis of the HCFA mortality data presented for 1986, there are three specific areas that need to be addressed. First the validity of the specific data, second the variables associated with specific categories as they relate to Auburn Faith Community Hospital and third, the use of this data as a tool for measuring quality care throughout our medical community.

1. DATA

The overall mortality figures appear to be correct for deaths that occurred within the hospital. Deaths outside the facility have not been totally confirmed. Of our total thirty seven out of hospital deaths, all have had appropriate referrals from Hospital Discharge Planning and Social Services. Thirty four patients were transferred to skilled nursing facilities, two were transferred to other acute hospitals and sixteen were discharged home with support services through local agencies in the community.

Coding Error - Ophthalmological Disease

Patient [REDACTED]	CRMI	3729	Conjunctivitis - Incorrect
	AFCH	3229	Meningitis - Correct

Patient was admitted with meningitis and co-morbidities of multiple myeloma and hypertension. He was later transferred to a skilled nursing facility and expired six days later.

Corrected Statistic:

EY	2 cases	Actual Mortality 0%
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As our number of cases are small, it tends to skew any attempt to provide meaningful percentage statistics. The above example is representative of our concern. Two cases, one erroneous death indicated 50% actual mortality rate in data provided.

VARIABLES - Not Reflective in Actual Statistics

The hospital service area is composed of a large retirement age population. Healthcare providers have been diligent in their efforts to provide alternate methods of healthcare to avoid acute admissions to Auburn Faith Community Hospital. As a result patients, when admitted to the facility, are of a much higher acuity and often in the terminal stages of their disease. We have members of our Medical Staff that specialize in the areas of oncology, pulmonary medicine, and cardiology that treat this large elderly population. The basic data provided only reflects the primary admitting diagnosis and does not allow for all the co-morbidities that are inherent with all Medicare admissions. Therefore, an assessment of the documented mortality rates would in no way reflect the actual cause of death or its relationship to the care provided.

3. QUALITY ISSUES

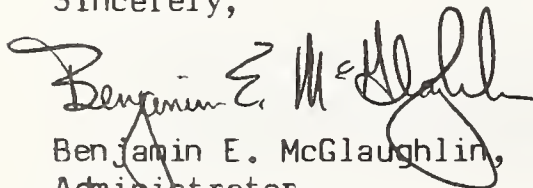
As a part of healthcare's, overall need to monitor its quality of care, it is understandable that there be an attempt to coordinate a data base which would accomplish a wide variety of needs. We need to address specific utilization of services, appropriate levels of care, unusual occurrences, competency of care givers on an on-going basis to assure that established standards are being met.

However, the base data provided by this study is only a preliminary tool at best for future investigation. It does not address the multiple variables related to disease, nor do the percentage rates reflect care provided.

As a healthcare provider, we will use this information to identify any specific areas for additional review, but in order to do an effective quality review, additional indicators and criteria must be identified for an assessment of patient care.

In conclusion, as individuals review this data, they need to realize the limits of its usefulness in trying to measure the appropriateness of care provided by an institution. As they perceive areas of concern they should contact the specific facility for clarification of data and assistance in its interpretation. Only then can they be sure of the competency of staff and appropriate services; and overall commitment of the institution to provide for their individual healthcare needs.

Sincerely,


Benjamin E. McGlaughlin,
Administrator
BEM:pk



BAKERSFIELD
**Community
Hospital**

901 Olive Drive • P.O. Box 5900 • Bakersfield, CA 93388 • (805) 399-4461

October 23, 1986

Roy D. Friedlos, Chief Executive Officer

Thank you for the opportunity to provide input on the 1986 Mortality Data.

Bakersfield Community Hospital is a 64 bed general acute care hospital, fully accredited by the Joint Commission on the Accreditation of Hospitals. Our Quality Assurance Program requires that the medical records of all patients who expire here be reviewed for the quality and appropriateness of the care that is given to each individual patient. The Quality Assurance Program at Bakersfield Community Hospital is designed to ensure the continual improvement of the quality of care rendered and carry out our commitment to excellence.

The data has been reviewed and validated by the Director of Medical Records, and with a few exceptions, is correct. It is noted that the mortality rates for Bakersfield Community Hospital in all 15 categories are within or below the "range of predicted mortality rates".

In 5 categories, which included 78 patients, we had no deaths. In 5 other categories, which include 91 patients, we had only 9 deaths. All of these patients had multiple major medical conditions and 8 were a "No Code" (do not resuscitate) status. One patient expired in spite of intensive resuscitative efforts which included placing the patient on a respirator.

In the category of Pulmonary Diseases, which is our largest category, we had 16 deaths out of 57 cases. Again, all 16 of these patients had multiple major medical problems, including several with advanced cancer. Five of these patients were in respiratory failure; 3 were in renal failure. Eight of these patients were "No Code" since the time of admission. Three patients expired after discharge and it is not know if their death was related to the reason for their hospitalization. Review of the medical records of these 3 patients showed that all were stable and ready for discharge at the time they were released from the hospital.

All 4 of our cancer patients who expired were in the terminal stage of their disease and were "No Code".

The Medical Staff of Bakersfield Community Hospital, as has been their practice, will continue to ensure that all mortality cases are reviewed for the quality and appropriateness of care; however, Mortality Review is just one component of the comprehensive Quality Assurance Program to which they are committed.

Sincerely,

Roy D. Friedlos
Chief Executive Officer

Edward P. Brown, M.D.
Chief of the Medical Staff

TERRACE PLAZA MEDICAL CENTER

October 22, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

SUBJECT: MEDICARE MORTALITY STATISTICS

Dear Doctor Roper:

In response to HCFA's Medicare mortality statistic report to be made available to the public this December, we would like to make the following comments:

- o Severe acute heart disease category showed a 78% mortality rate. It is important to note that the average age of patients in this category is 76 years and they generally are admitted from nearby convalescent hospitals with an unusually higher number of complicating or comorbid conditions associated with heart disease. These patients have chronic degenerative conditions and may be admitted shortly before death. It is a high risk diagnostic category based on the patient's general health status which is generally very poor.
- o Sepsis category reflected a 100% mortality rate based on two (2) patients of ages 102 and 91 respectively. This small sample size greatly skews the data and mortality rate and is not a true reflection of the overall medical management provided to patients treated for sepsis.

Thank you for the opportunity to comment on these mortality statistics.

Sincerely,



Rolland E. Wick
Executive Director

REW:cdk

Bellwood General Hospital

10250 East Artesia Boulevard
Bellflower, California 90706

(213) 866-9028

October 27, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

RE: Hospital Mortality Data/Bellwood General Hospital
Provider #050486

To Whom it May Concern:

Thank you very much for the opportunity to review the data collected on Medicare Beneficiary Mortality Rates for the year 1986.

In reviewing the data, our Medical Records Department has determined that one patient was listed twice in the report. The data was otherwise substantially correct.

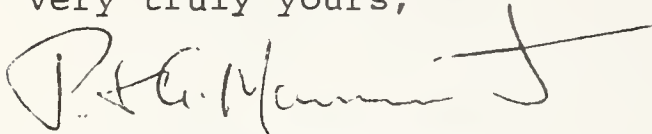
Bellwood General Hospital is an 85-bed acute care general hospital. Included among the many programs we offer is an extensive Geriatrics Service. As a result of the interest of our Medical Staff in Gerontology, a large number of our hospital admissions are the result of nursing home and other facility transfers. A review of the data found in the HCFA Report demonstrates that approximately 76% of these mortality cases involve patients received from other such facilities.

As a result of the unique population for which we provide care, the age distribution of the patients within this report showed approximately 76% were 75 years of age and older. Of this group, nearly 60% were older than 85 years old.

In catering to the wishes of our patients and their families such issues as "Living Wills", "No Codes" and the "California Natural Death Act" are addressed and followed. Naturally these practices impact on the statistical report being compiled.

It has been the longstanding practice of the Bellwood General Hospital Medical Staff to conduct in depth review of all cases which result in mortality. Through these review activities, high quality standards are maintained. Additionally, this in depth case review provides an educational forum for our Medical Staff to continually analyze and improve the quality of care provided to our patients.

Very truly yours,

A handwritten signature in dark ink, appearing to read "P. A. Marmerstein", with a long horizontal flourish extending to the right.

Peter A. Marmerstein
Administrator

PAM:sds



Beverly Hills Medical Center

1177 South Beverly Drive
Los Angeles, California 90035
Tel. (213) 553-5155

October 20, 1987

William Roper, M.D.
Administrator
Department of Health & Human Services
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

Pursuant to receipt of your recent letter and HCFA mortality data, we have reviewed the referenced listings and correlating patient records. The following represents our findings and comments.

According to hospital records, of the 68 listed patients, HCFA data represents the incorrect date of death in six (6) cases or 8.82% of total cases. Additionally, in seven (7) cases, there are discrepancies between the principal diagnosis as indicated by HCFA data and as documented by the hospital.

Eighteen (18) of sixty eight (68) patients died after discharge. Of these, ten (10) expired after at least a one week period and six (6) after two weeks. The average number of days post discharge of those patients having expired within 30 days of discharge was 8.83.

A pertinent note is that one patient [REDACTED] listed as having expired in the hospital of low risk heart disease was in fact discharged in stable condition.

The coding discrepancies (see attached) do not significantly change the mortality rates as noted by HCFA for Beverly Hills Medical Center. All listed actual mortality rate percentages are within the predicted range, with 56.25% falling in the lower half of the predicted range.

Worthy of comment for discussion of mortality data for this hospital is the fact that Beverly Hills Medical Center is situated in the midst of a community heavily populated with senior citizens. Also the hospital has a very active Emergency Room which is responsible for a significant

William Roper, M.D.
Page 2

portion of our admissions. Given these factors and the above data as prescribed by HCFA, we feel we are continuing to meet the high standards of quality care within a full service acute care facility setting.

Sincerely,

BEVERLY HILLS MEDICAL Center

A handwritten signature in dark ink, appearing to read "J. A. Ashin".

Jeffrey A. Ashin
Executive Director

DS:pfl
encl.

BEVERLY HILLS MEDICAL CENTER

CODING DISCREPANCIES

The following represents the principal diagnosis as listed by HCFA versus principal diagnosis as documented by the Hospital for those patients where review indicates a discrepancy.

HCFA	198.3	Metastasis to Brain/Spinal Cord
Hospital	162.9	Cancer of Lung .
HCFA	560.39	Intestinal Obstruction
Hospital	434.0	Cerebral Thrombosis
HCFA	599.0	Urinary Tract Infection
Hospital	038.9	Septicemia/Sepsis
HCFA	721.9	Spondylosis
Hospital	276.5	Dehydration
HCFA	482.4	Pneumonia
Hospital	431.	Intracerebral Hemorrhage
HCFA	038.42	Septicemia/E. Coli
Hospital	486.	Pneumonia
HCFA	799.1	Cardio Respiratory Failure
Hospital	436.	CVA



October 24, 1987

Health Care Financing Administration
Hospital Mortality Information
Box 26684
Baltimore, MD. 21207

Attached are the comments on the Medicare mortality
data for Brea Community Hospital.

Sincerely,

William F. Pfisterer, M.D.
QA/UR Chairman

R. Gordon Hepworth, M.D., F.A.C.S.
Medical Director

mb



HOSPITAL # 050592

RE: Mortality Statistics-1986

Thank you for the opportunity to respond to the release of data on hospital mortality rates for the year 1986. An ongoing review of all patients who died within 30 days of hospitalization in our facility occurs in continuing committee evaluations throughout the year. The charts have also been re-evaluated by Quality Assurance data following the presentation to the hospital of the HCFA numbers for deceased patients. The Director of Medical Records has ascertained that, with minor exceptions, the data is accurate.

The hospital has a full time Medical Director responsible for the Quality Assurance and Utilization Review program who has also reviewed all the cases reflected in this report.

It is worthy to note that Brea Community Hospital has remained well within the range of predicted mortality rates enunciated by HCFA.

The list sent by HCFA identified 102 cases who died either in the hospital or within 30 days of discharge. The number of Medicare cases treated was 908. The range of predicted mortality rates was 8 to 16 percent. Our reported percentage is 11%, well within this range.

The following analysis identifies the cases by cause of death with notes relating to any accompanying disease.

CANCER

The predicted percentage was 12 to 34%. Ours was 16%.

There were 9 cases identified where the cause of death was identified as cancer. Of these cases five showed widespread malignant disease involving more than one organ of the body and one other case suffered from leukemia and declined any form of treatment. Of the other three cases one was a reticulosarcoma with widespread disease, congestive heart failure and anemia who wanted to die at home, one had an inoperable brain tumor, and the ninth case had inoperable cancer of the esophagus.

CEREBROVASCULAR ACCIDENTS (STROKE)

The predicted mortality rate was 14 to 46%, our actual mortality rate was 34%

Ten (10) cases of death were considered directly related to stroke. Of these, 3 patients had one or more previous strokes, one refused further treatment and was transferred to an extended care facility and died two weeks later, eight patients had two or more other life threatening diseases ranging from congestive heart failure, malignancy, pneumonia, metabolic disease, & organic heart disease. Five patients suffered

from high blood pressure and two were non-compliant with their medication. Four patients (4) were "no code status" by family request. Age of patients was 95, 91, 86, 85, 82, 81, 75, 73, 68, 68. Of the latter two patients one suffered from results of chronic alcoholism and the other had concurrent malignant disease

OPHTHALMOLOGICAL DISEASE

The predicted mortality varied from 0 to 100%.
Our mortality rate was 0%.

GASTROINTESTINAL CATASTROPHIES

Predicted rate was 6 to 32%
Our rate was 10%

Nine (9) patients were identified with severe onset of gastrointestinal disease. Of these, three patients aged 84, 80 and 67, were inoperable, "no code" and either the patient or the family did not want surgery in any case. Two patients aged 90 and 85 refused corrective surgery; two patients had cancer and abdominal bleeding was a terminal event and one other patient who developed severe respiratory problems post operatively had multiple diseases and all supportive measures were withdrawn at the request of the family. One 72 year old patient with multiple diseases had gangrene of the colon, underwent surgery, but developed severe heart disease and expired. This patient also had cancer of the lung.

GASTROINTESTINAL DISEASE

The predicted mortality rate was 2 to 12%.
Actual mortality rate 10%.

Eight patients were identified whose death was directly related to the above. Four of the patients had malignant disease of which three had wide-spread disease and one was inoperable due to seven other serious accompanying disease processes. A second patient age 77 with a gastric ulcer and gallstones was first treated without surgery due to serious heart disease but did not respond to any therapy. Attempted surgery was performed successfully but the patient's heart condition worsened and he sustained a pulmonary embolism and expired thirteen days post operatively. The next patient had a bowel perforation with malignancy of the colon and an inadequate blood supply to the bowel. Patient had chronic alcoholism with liver disease and also septicemia. The patient was aggressively treated but despite therapy developed cardiac arrest three weeks following surgery but had been made "no code" by the family. Of the two other patients one was a 92 year old patient with an esophageal stricture and colon cancer who was terminal and the other was a 75 year old patient with chronic esophagitis, severe pulmonary disease and coronary artery disease. This patient expired 19 days later at an extended care facility and the cause is unknown.

UROLOGICAL DISEASE

Predicted mortality rate 1 to 17%
Actual mortality rate 6%

Three patients were identified as having died with a primary diagnosis of urinary tract disease. The patients were aged 97, 96 and 66. Two patients died from urinary tract infection which had resulted in septicemia and one patient had multiple other diseases which contributed to death. All three patients had been made "no code" at the request of the family.

LOW RISK HEART DISEASE

Predicted mortality rate 2 to 13%

Actual mortality rate 1%

SEVERE CHRONIC HEART DISEASE

Predicted mortality rate 12 to 35%

Actual mortality rate 15%

Two patients were identified with severe chronic heart disease contributing to this mortality rate. One patient had recurrent myocardial infarcts, developed pneumonia, congestive heart failure, and expired and there were numerous other contributing diseases. The second patient had long standing heart disease and was admitted comatose and in heart failure and expired. All other patients in this category had other serious disease which was the actual cause of death.

SEVERE ACUTE HEART DISEASE

Predicted mortality rate 21 to 62%

Actual rate mortality rate 48%

Six cases were identified where the primary cause of death was considered to be severe acute heart disease: #1 age 66. This patient with an acute myocardial infarction refused admission to hospital and went home. Later that day he returned to the hospital with persistent pain and hypotension and was admitted to intensive care where treatment was instituted and the patient suffered cardiac arrest. Since he had requested "no code" status a code was not called and he expired. #2 a 75 year old patient with angina had two myocardial infarcts and was admitted to the hospital. Despite all possible measures, including a code blue, he expired within 24 hours of admission. #3 This 72 year old patient with known heart disease, previous coronary artery bypass surgery and carcinoma of the pancreas was admitted with ventricular tachycardia, had to be defibrillated three times and despite CPR expired the day of admission. #4 This patient aged 70 had known cardiac arrhythmia, was admitted with chest pain and had an arrest on the second hospital day and expired. Patient also had chronic obstructive pulmonary disease, urinary tract infection, diabetes mellitus. #5 This 88 year old asthmatic suffered an anterior myocardial infarct, developed congestive heart failure which complicated the asthma and was made "no code" by the family and expired on the 12th hospital day. #6 This 85 year old patient was admitted unconscious having suffered a stroke and an acute myocardial infarction. Family wished "no code" status and the patient died the day of admission.

METABOLIC/ELECTROLYTE DISTURBANCES

Predicted Mortality rate 9 to 43%
Actual mortality rate 32%

Eight cases where metabolic causes were directly related to the cause of death were identified. Four of these cases age 93, 81 and 74 were terminal cancer cases. Of the other four, one patient had kidney failure with electrolyte imbalance, the second patient had kidney failure with electrolyte imbalance with alcoholic heart and liver disease, gastric ulceration, severe chronic respiratory disease, systemic vascular occlusion. The third patient of this group was a 67 year old patient with Crohn's disease causing severe, recurrent dehydration. The patient was considered terminal but received aggressive treatment. There had been numerous bowel obstructions. Metabolic imbalance was the terminal event. The last patient in this group was a 91 year old patient with diabetic ketoacidosis, congestive heart failure and debility who was considered terminal and expired at an extended care facility.

ORTHOPEDIC DISORDERS

Predicted Mortality rate 0 to 11%
Actual mortality rate 4%

Three patients were identified as having an orthopedic condition directly related to death. #1 The patient was discharged on the 8th day following a procedure on the left knee and was being treated by a Home Health Agency. She was subsequently found dead in the bathroom and suspected cause of death was pulmonary embolus or myocardial infarction. #2 This patient underwent subluxation of C3 to 4 and developed quadraplegia. She had numerous other diseases including pulmonary disease, urinary tract disease, seizures, berry aneurysm. She was not a candidate for surgery and ultimately expired in an extended care facility. #3 This 84 year old patient was confused, had a retro-peritoneal mass with lumbar disc disease and congestive heart failure and ultimately expired. No surgery was attempted.

PULMONARY DISEASE

Predicted Mortality rate 12 to 30%
Actual mortality rate 20%

Fifteen patients were identified. Of these ten had pneumonia as the primary cause of death and it should be noted that all but three of these patients were aged 83 to 101. The other three being 70, 75 and 79. All these patients had numerous other complicating diseases which ranged from malignancy to congestive heart failure and chronic obstructive pulmonary disease. The other patients in this category (5) all suffered from chronic airway obstruction and all patients had other concomitant diseases which contributed to their death.

RENAL DISEASE

Predicted Mortality rate 6 to 52%
Actual mortality rate 13%.

Three cases were identified where renal disease could be considered the primary cause of death. One patient was admitted with acute renal failure but also had serious heart disease, chronic brain syndrome, chronic airway obstruction, hepatitis, and blood in the stools. The family requested "no code" and that no heroics be undertaken. The patient was given supportive care and died on the second day of hospitalization. The second patient was an 86 year old male with renal failure, congestive heart failure, vascular disease, previous gangrene of extremities and serious ulcerations in the sacral area. At the family's request the patient was made a "no code" and died a few hours after admission. The last patient was 78 years old and was admitted from an extended care facility. There was a diminished urine output but the patient improved and was able to be discharged from the hospital to an extended care facility where he subsequently died, actual cause unknown.

SEPSIS

Predicted Mortality rate 19 to 71%
Actual mortality rate 17%

Numerous cases of pneumonia and peritonitis obviously fall in this category, but have been discussed under other sections because the septic process was not the primary cause of death.

Three cases have been identified in which sepsis is considered likely to have been the cause of death. The first was a 73 year old diagnosed as tuberculous viremia. This patient was placed on multiple drug regimes for a positive blood culture. The family refused to allow any life support systems and wished to take the patient home but the patient expired the day of this request. Autopsy was refused. Tuberculosis was not confirmed and this may have been a septicemia caused by some other organism. Patient also had renal failure. The second patient was admitted with a staphylococcal septicemia which did not respond to antibiotic therapy. At the request of the family, the patient was made a "no code" and expired. The patient was also a diabetic. The third patient had a cellulitis. Patient was being treated for cancer, site unknown, with extensive disease in the lymph nodes and was considered terminal. The patient died nine days after discharge on supportive therapy, but the actual cause of death is unknown.

SEVERE TRAUMA

Predicted mortality rate 2 to 36%
Actual mortality rate 6%

In reviewing all the death charts for 1986 we were unable to identify any cases of severe trauma. The hospital is not a trauma center.



BROOKSIDE HOSPITAL

JOHN P. FRIEL
Chief Executive Officer

DIRECTORS
JANE BEAM WOOD
President

BETTYE J. CASH
Vice President

JUDITH COLEMAN
Treasurer

KEVIN GERAGHTY, M.D.
Secretary

VERNON T. ARCHIBALD, M.D.
Assistant Secretary

October 21, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. BOX 26684
Baltimore, Maryland 21207

Dear Health Care Provider,

Thank you for the opportunity to respond to the release of 1986 data on hospital Medicare mortality rates.

Brookside Hospital is pleased that the high quality of care provided to our community is reflected in the results of your study. The hospital's mortality rates for every diagnostic category you studied were within the accepted designated ranges.

Brookside Hospital is a 246 bed acute care facility which offers programs to the community that attract seriously ill and terminal patients. The hospital treats a high volume of Cardiovascular, Oncology, End Stage Lung and Renal disease patients. In addition, the hospital maintains a Regional Burn Center, Coronary Care Unit, Surgical Intensive Care Unit, Medical Intensive Care Unit, and an Oncology Unit.

We appreciate the fact that your analysis took into consideration our case mix, which is reflective of the large number of elderly and seriously ill patients in our community.

It should be noted that our Medical Staff Committees monitor all deaths in our facility on an on going basis as a part of our Quality Assurance Program. This provides us with a mechanism to ensure that we continue to meet and exceed quality care standards.

Again, thank you for the opportunity to present this response.

Sincerely,

John P. Friel
President/Chief Executive Officer

Khosrow Afsari, M.D.
Chief of Staff

HCA Brotman
Medical Center

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Washington, D.C., 20201

October 26, 1987

Dear Dr. Roper:

Thank you for the opportunity to respond to HCFA's release of hospital mortality rates for 1986. Brotman Medical Center is pleased that its results came within the range of predicated mortality in every single category, and at the lower end of the ranges in eleven (69%) of the sixteen categories.

Our review of the data included a verification of all in-hospital deaths. One patient was found to be included in error, as this patient was discharged, readmitted at a later date and discharged alive.

While all of Brotman's sixteen (16) categories were within the predicted ranges, we reviewed the five (5) categories with results above the midpoint end of the ranges.

Over 35% of all 1986 admissions to Brotman Medical Center came through our Emergency Department, a Paramedic Base Station. Of those deaths, which occurred in the five categories noted above, over 70% were admitted through the Emergency Department in an urgent or critical condition.

As a major Cardiac Center, it was not surprising to find that the most critically ill cardiac cases were brought to Brotman. The data revealed that, in the category Severe Acute Heart Disease, over 85% of all subsequent deaths were admitted through the Emergency Department and that over 40% of all deaths in this category occurred within the first 24 hours of hospitalization.

It is noteworthy that in spite of providing Burn, Cardiac, Cancer and Pulmonary Centers Brotman's mortality rates fell within the predicted ranges in all categories.

Sincerely,



Ronald Phelps
Administrator

Attachment

PO Box 2459
3828 Delmas Terrace
Culver City, California 90231-2459
Telephone (213) 836-7000
A subsidiary of HCA - The Healthcare Company

Brotman Medical Center

Medicare Provider Number:

Patient [REDACTED] was found to have been discharged alive, readmitted and discharged alive. In any event, your log shows this patient to have been discharged five days after the date of death.



CALIFORNIA MEDICAL CENTER
LOS ANGELES

William F. Haug
President & Executive Director

October 26, 1987

Department of Health & Human Services
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Community:

We'd like to take this opportunity to comment on the mortality data released by the Health Care Financing Administration (HCFA).

California Medical Center is an acute care, teaching hospital based in the Central City of Los Angeles. We offer comprehensive cancer care, 24-hour emergency services designated as the "first hour" emergency care facility by the American Heart Association, specialized obstetrics and gynecologic care, including high-risk pregnancy, neonatal and intensive care services; orthopedic surgery, rehabilitative medicine, cardiology and general medicine and surgery. Many of our patients have illnesses that can be considered severe. A substantial portion of our patients come from an area of the city that is considered underserved in terms of preventive medicine. This often results in patients having more severe illnesses or advanced stages of illness when they are hospitalized at California Medical Center.

The HCFA mortality data has been carefully reviewed by me, along with other administrators, the Chief of Medical Staff, Director of Utilization Review, Quality Assurance and Medical Records and our Director of Nursing. Our overall mortality rates fall well within the predicted ranges and in several categories are in the lower end of the spectrum.

To put this in perspective, we'd like to give you some background about the mortality review process at California Medical Center:

The medical staff conducts intensive review of the medical record of every patient who expires, looking at overall medical management and care;

Mortality review is an ongoing process of the attending medical staff;

Review is also part of the ongoing process of the Quality Assurance program and peer review activities as an integral part of the monitoring of health care delivery at our Medical Center.

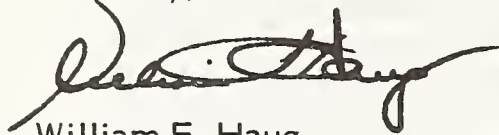
Our mission is to consistently provide high quality health care. We share your concern about the care that you receive by health care providers and we also support your right to know how well this care is managed. To that end, as I stated earlier, we do examine mortality data on an ongoing basis as part of the peer review and quality assurance processes. We also take several other steps to ensure quality care.

These quality assurance steps include attaining accreditation from the Joint Commission on the Accreditation of Hospitals. This three-year accreditation, which was recently bestowed on California Medical Center demonstrates our "organization's commitment to quality patient/client care" We also recruit and retain the most highly skilled medical and nursing professionals in the region. California Medical Center has also substantially increased its community education program with an emphasis on preventive medicine. The community outreach program includes health fairs, perinatal classes and prevention of prematurity classes along with health and fitness programs for seniors. We also continue to invest resources in the latest advances in diagnostic and treatment technology.

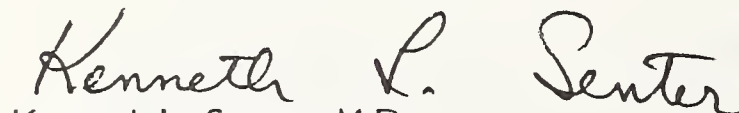
We are proud to have been a part of this community for 100 years. As has always been our practice, we will continue to review our health care services in an effort to consistently provide quality care.

Thank you for this opportunity to present these comments.

Sincerely,



William F. Haug
President and Chief Executive Officer



Kenneth L. Senter, M.D.
Chief of Medical Staff

DEPARTMENT OF DEVELOPMENTAL SERVICES

CAMARILLO STATE HOSPITAL

BOX 'A', CAMARILLO 93011

PUBLIC NO. 805-464-3661

ATSS NO. 644-0011



October 22, 1987

William L. Roper M.D.
Administrator,
Health Care Financing Administration,
Washington, D.C. 20201

Dear Doctor Roper:

We are commenting on HCFA's mortality statistics which you say you will publish at the end of the year.

Camarillo State Hospital falls within your predicted mortality rates in all categories except one.

That one category is metabolic/electrolyte disturbances. In this category our rate was 100%. Your prediction was 92% at most.

We have very few deaths. Therefore, the percentage looks large. But the percentage derives from two cases. With only two cases, the predicted range has little application, especially for our hospital.

Camarillo State Hospital is a highly specialized hospital of 1200 patients. We have two types of patients, mentally retarded clients and mentally disordered patients.

Within our very large hospital, we have a very small acute hospital unit. This is to care for medical problems which arise after admission. We are equipped and staffed to take care of minor and moderately severe medical and surgical cases.

Less frequently encountered and severe medical and surgical cases require closer monitoring than we can provide. These are transferred to one of four other teaching hospitals, if it will result in better care.

We have highly trained staff. Most of our doctors are Board Certified in their speciality. In addition, competent consultants from surrounding communities complement our in-house staff.

We had a 100% autopsy rate in 1986. We look very closely at each death in Mortality Review Committee. Every death is reviewed by the entire Medical Staff.

Our standards of care are high. These two deaths were unavoidable.

Thank you for the opportunity to clarify your mortality data.

Sincerely,

Sarla Gnanamuthu M.D.

Sarla Gnanamuthu M.D.
Medical Director

Frank Turley

Frank Turley Ph.D.
Executive Director

Canoga Park Hospital
20300 Sherman Way
Canoga Park, CA 91306
(818) 348-0200

Member of:
California Hospital Association
Western Hospital Association
Hospital Council of Southern California
Accredited: J.C.A.H

Barbara Meyers,
Administrator



October 16, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

We request that the following comments be published with the mortality statistics regarding Canoga Park Hospital:

A special committee comprised of members of the medical staff, nursing and quality assurance personnel reviewed the charts of 75% of all of the hospital's patients represented in the HCFA Mortality Study. It was found that the average age of the patients was 81 years and in 70% of all of the cases, the immediate family had requested that no heroic measures be taken.

Thank you for giving us the opportunity to respond to the statistics prior to publication of the Study.

Sincerely,

Barbara Meyers

Barbara Meyers
Administrator

bcm



CEDARS-SINAI MEDICAL CENTER

Reply to:
Box 48750
Los Angeles, California 90048-0750
Direct Dial Number: (213) 855-5154

October 21, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Enclosed please find the comments to be distributed with the 1986 Mortality Statistics for Cedars-Sinai Medical Center (Hospital # 050625).

If you have any questions, please feel free to contact me.

Sincerely,

James R. Klinenberg, M.D.
Vice President for Professional Services

JRK/lr

Enclosure



CEDARS-SINAI MEDICAL CENTER

Reply to:

Box 48750

Los Angeles, California 90048-0750

Direct Dial Number: (213) 855-

5154

Medicare Provider #050625

October 21, 1987

To Whom It May Concern:

The Health Care Financing Administration (HCFA) has made available the attached data about the mortality rates of Medicare patients treated at Cedars-Sinai Medical Center compared to a range of predicted mortality rates. This letter is provided to assist in the interpretation or evaluation of this summary information.

Cedars-Sinai Medical Center is a 1201-bed acute care hospital with comprehensive medical and surgical services, as well as teaching and research programs. With annual discharges in excess of 39,000 patients per year, Medicare recipients represent less than half of the patients treated at the Medical Center.

Our state of the art, high technology facilities, in conjunction with the expertise of our medical staff, create an environment where patients who are more seriously ill come for treatment. For example, our ratio of intensive care beds to routine care hospital beds is one of the highest in the nation, thus attracting not only patients who have an immediate need for intensive care, but also those who have a great potential for requiring such care some time during their hospital stay. Further, our medical staff of over 2,000 physicians is largely composed of subspecialists, who choose to admit their most complex, referred cases to Cedars-Sinai. The medical education programs for residents and fellows, together with the associated academic faculty, also help to encourage the admission of patients with complex medical care needs. Specific programs at Cedars-Sinai Medical Center which contribute to a patient population requiring more complex hospital resources include an Emergency Department which serves as a Paramedic Base Station and Level 1 Trauma Center; a multidisciplinary cancer program with comprehensive inpatient and outpatient diagnostic and treatment services; and our cardiology service which includes programs in open-heart surgery, critical care, arrhythmia detection and treatment, and rehabilitation.

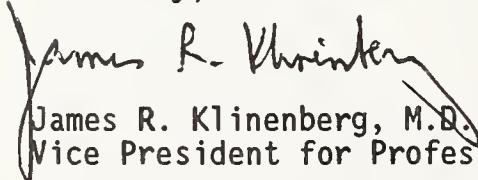
October 21, 1987
Page Two

Cedars-Sinai Medical Center is committed to the delivery of the highest quality care to the patients it serves. To evaluate and improve the quality of patient care, we have developed extensive, on-going Quality Assurance and Peer Review programs, of which mortality review is an integral part. Our medical staff carefully evaluates the medical management and overall care of each mortality occurring in the Medical Center. This kind of review affords us the opportunity to develop new programs or procedures to meet the needs of our patient population.

Our analysis of the HCFA mortality data for Cedars-Sinai Medical Center revealed that 99% of the listed patients appear in our inpatient data base. Accordingly, we feel that the data and analysis performed by HCFA are highly reliable. The data has also been reviewed by the Medical Center's medical director, administrators, director of Quality Assurance, Utilization Management Group, and members of the medical staff. We note that our mortality rates fall below the midpoint of the predicted range of mortality in patient populations somewhat similar to our own. In fact, our rates are equal to or lower than the minimum of the predicted mortality rate range for several diagnostic categories. We realize, however, that mortality rates, per se, are just one type of indicator in the complex analysis of quality care, and cannot substitute for the continued Quality Assurance programs in operation at our Medical Center.

We appreciate the rising public interest in having available objective information of the quality of care rendered at our nation's hospitals, and we are encouraged by HCFA's improved techniques in reporting mortality statistics. Future, appropriate reports of indicators of quality of patient care are certainly welcome.

Sincerely,



James R. Klinenberg, M.D.
Vice President for Professional Services

JRK/lr

Centinela Hospital Medical Center

Official Hospital for the 1984 Olympic Games

October 21, 1987

Health Care Financing Administration
Health Standards Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21201

To Whom It May Concern:

The following information for Centinela Hospital Medical Center, Provider #050240, re: Medicare patients treated at this facility in 1986, is to be attached to the HCFA Hospital Specific Mortality Data Report, prior to public disclosure.

Centinela Hospital Medical Center is a 402-bed acute care facility, whose case mix includes many patients with major medical and surgical illnesses. We are a full-service medical center offering care in speciality areas of oncology, open-heart surgery, major orthopedic services, rehabilitative medicine, dialysis, as well as general medicine and surgery.

The Medical Staff at Centinela Hospital Medical Center conducts an intensive review of the medical record of every patient who expires at this facility. Mortality review is an ongoing process of the Quality Assurance program and peer review activities that are an integral part of the monitoring of the healthcare delivery system at this hospital. The Joint Commission on Accreditation of Hospitals bestowed on this facility its highest commendations for its Quality Assurance program and excellent peer review process that is performed.

The hospital specific mortality data submitted by HCFA has been carefully reviewed by: the hospital administrators, President of the Medical Staff, Physician Chairman of the Utilization Review Committee, Director of Utilization Review & Quality Assurance and the Director of Medical Records.

The Directors of Medical Records and Quality Assurance validated the HCFA data and found with some exceptions that the data is reasonably accurate when compared with this facility's statistics.

The actual mortality rate at this facility was well within the acceptable range identified by HCFA.

HCFA's data indicated 23.8% of the total number of deaths occurred after discharge. We would like to state that the hospital has no way of knowing the actual cause of death after a patient is discharged and the death may be totally unrelated to the patient's hospital admission.

Review of the medical record of those patients who died after discharge indicated thirteen required extended care facility placement, nine were being seen on a regular basis by home health agencies and visiting nurses, and two were under the care of the hospice program. The remainder of the patients had adequate home support systems in place as verified by the social worker prior to the patient's discharge. The Social Service Department of this facility works with the physician, the patient and family to assure that our patients are discharged to a safe environment that best accommodates their medical needs. We feel discharge planning is a critical component of the healthcare process.

Assessment of this facility's documentation re: mortality review indicated to us that the HCFA data does not clearly account for the severity of illness that was present in a significant portion of the elderly population that received treatment here.

During our process of reviewing the HCFA data, the following was revealed:

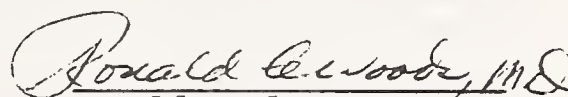
1. Cancer Category: Average age of patient 76.3 years.
 - ° All deaths were due to end-stage carcinoma with metastasis.
 - ° This facility has an excellent oncology (cancer) unit and thus treats a higher risk population within this disease category.
2. Cerebrovascular Accident Category: Average age of patient. 73.1 years.
 - ° 53.8% of these patients had massive strokes with irreversible damage.
 - ° 46.2% had acute CVA's but also had severe medical problems such as diabetes, hypertension and respiratory disease complicating their recovery.
3. GI Disease Category: Average age of patient 81.1 years.
 - ° The majority of these patients were admitted in serious condition with diagnoses including GI bleeding, massive intrahepatic bleeding and bowel obstruction with sepsis.
 - ° Complicating secondary diagnoses of diabetes, respiratory failure and CVA were present.
4. GU Disease: Average age of patient 83.5 years.
 - ° 50% of the patients in this category were admitted from nursing homes.
 - ° Review of this category also revealed that three of the eight patients primary diagnosis was not a urological one.
5. Low Risk Heart Disease: Average age of patient 75.8 years.
 - ° Patients in this category all had multi-medical problems including, chronic renal failure, end-stage congestive heart failure and pulmonary disease. Low risk heart disease does not seem to be an appropriate classification to reflect the severity of illness with which these patients presented to the hospital.
 - ° In this category there were also several patients who had metastatic carcinoma.

6. Severe acute heart disease: Average age of Patient 77 years.
- ° The most common cause of death in this category was acute myocardial infarction with shock.
 - ° Majority of these patients were emergency admissions in critical condition and with other complicating medical problems present in a significant number of cases, i.e., renal failure, diabetes and hypertension.
7. Orthopedic Disorders: Average age of patient 75.2 years.
- ° Two patients or 50% of the patients identified in this category did not have an orthopedic diagnosis and were mis-classified in the HCFA data.
 - ° Our actual orthopedic mortality rate is 1%. We treated 279 Medicare patients and had 2 deaths. Both of the deaths that occurred were patients admitted from nursing homes with fractured hips and multiple medical problems.
8. Renal Disease: Average age 73.0.
- ° Review revealed these were patients in end-stage chronic renal failure, on dialysis, with multiple medical problems.

Thank you for the opportunity to present this response.

Sincerely,


Russell Stromberg,
Hospital Administrator


Ronald Woods, M.D.,
Medical Staff President

Channel Islands
Community Hospital

October 1, 1987

William L. Roper, M.D.
The Administrator
Health Care Financing Administration
Washington, D.C. 20201

Dear Doctor Roper:

This letter is intended as a response to the mortality data forwarded to our facility along with your correspondence of September 21, 1987. After indepth review of our specific mortality data the following errors were found in HCFA's statistics; Six patients who were listed as expiring after they left our facility did indeed expire here. In one of those cases the admit and discharge date you have listed is incorrect. (Please see attached list for corrections.)

In review of the four cases that did expire subsequent to discharge from our facility, it was found that two were transferred to an area extended care facility and two to another acute care facility. All four of these patients were severely ill, one with no code order requested by the physician and family. The reason for the transfers to the alternate acute hospital was to enable the patient further treatment which was not available at our facility.

The one area in which our hospital exceeded the range of predicted mortality was in the category of sepsis, in which we had only one patient, leading to a 100% mortality rate. Similarly, in the area of severe chronic heart disease our patient volume of four, three of which expired, resulted in a high mortality rate for that category. These types of patients were very debilitated and experienced numerous comorbid conditions; such a small sample of patients does not accurately reflect patient management.

Thank you for this opportunity to respond. Should you have any questions, please feel free to contact me.

Sincerely,



Emma Mayer Orr
Administrator
Channel Islands Community Hospital

EMO;ljb

Enclosures

**Channel Islands
Community Hospital**

Corrections To HCFA Data

<u>Patient #</u>	<u>Name</u>	<u>Actual Date of Death</u>	<u>HCFA Date of Death</u>
[REDACTED]	[REDACTED]	10/07/87	10/16/86
[REDACTED]	[REDACTED]	08/20/86	08/31/86
[REDACTED]	[REDACTED]	04/06/86	04/08/86
[REDACTED]	[REDACTED]	12/26/86	12/29/86
[REDACTED]	[REDACTED]	04/10/86	04/10/86
		admit 04/10/86	HCFA admit 03/22/86
			HCFA disch 04/01/86
[REDACTED]	[REDACTED]	01/13/87	01/13/87
		admit 01/07/87	HCFA admit 12/18/86
			HCFA disch 12/27/86

Charter Suburban Hospital
Serving Southern California with Quality Health Care

16453 South Colorado Avenue
Paramount, California 90723
Telephone (213) 531-3110

October 26, 1987

Health Care Financing Administrator
Health Standards and Quality Bureau
2D2 Meadows East Bldg.
6300 Security Blvd.
Baltimore, Maryland 21207

Attention: Mr. Harvey Brooks

To the Public Which We Serve,

Charter Suburban Hospital is a 184-bed acute care facility, whose patients present with complex medical problems and illnesses. We are a full service medical center offering care in the specialty areas of medicine and surgery.

The hospital care at Charter Suburban Hospital focuses on a Senior Health Program (Medi-Prime) that maintains the dignity of older patients, while promoting restoration of their optimum level of health. Among the Senior Health Programs offered are the Senior Fitness Program, including Tai Chi, Diabetic Management, Blood Pressure Monitoring, Arthritis Self-Help Course, Podiatric Screening and others.

The Lifeline Program at this facility is a personal emergency response system which provides immediate access to medical assistance on a 24-hour basis. The hospital also promotes Senior Health Wellness through the Walkers' Club (Walk for the Health of It").

Charter Suburban also provides medical service to 25 nursing homes in the immediate area when patients become acutely ill.

The Medical Staff at Charter Suburban Hospital conducts an intensive review of the medical records of patients expiring in the facility. Their goal is to maintain the highest quality of care through the peer review process. The Joint Commission of Accreditation of Hospitals bestowed on this facility its highest commendation for the Hospital Quality Assurance Program and the excellent Peer Review Process.

Mortality Review data has been thoroughly reviewed by the Hospital Administrator, Chief of Medical Staff, Physician Chairman of Utilization Review/Quality Assurance, individual specialty physicians and the Q.A., U.R. and Medical Records personnel. As previously stated, reviews do occur on an on-going and timely basis by individual cases, through peer review as a mechanism of Quality Assurance.

Health Care Financing Administrator
Health Standards and Quality Bureau
Attn: Mr. Harvey Brooks
Page 2

October 26, 1987

Thank you for the opportunity to present this response.

Sincerely,



Administrator



Chief of Staff

cc: Medical Executive Committee



Chico
Community
Hospital

October 23, 1987

560 Cohasset Road
Chico, California 95926
(916) 896-5000

Provider #: 050307

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland, 21207

To those concerned about CCH Mortality Statistics:

Chico Community Hospital is pleased to have this opportunity to respond to HCFA's current release of mortality data. Since receiving the report on September 28, 1987 a number of people have had an opportunity to review the data:

1. Our Director of Medical Records has validated that with minor exceptions, HCFA's data is accurate and is a reflection of statistics at our hospital.
2. All deaths in all major diagnostic categories are reviewed on a regular basis by the appropriate medical staff speciality.
3. The Quality Assurance Committee, Medical Staff Executive Committee and Hospital Board of Governors monitor monthly statistics.

Based on this comprehensive review of mortality statistics at Chico Community Hospital, we think you and any member of the public who request a copy of our statistical information will be interested in the following:

The Chico Community Hospital actual mortality rate for medicare patients in 1986 was ten percent, well within the rate of HCFA predicted mortality rates of six to fourteen percent.

Chico Community Hospital is pleased to have a high percentage of medical staff members who are specialists. The many small rural hospitals in our area transfer high acuity patients with a multitude of diagnostic challenges to our physicians.

Chico Community Hospital is proud to have the Northern California Regional Burn Center. The trauma mortality rate is 11%, which is excellent for the number of burn patients seen, many of whom also have a multitude of other chronic conditions.

Lung problems such as emphysema, pneumonitis and influenza caused 334 deaths in Butte County during 1986. The rate of respiratory problems in Butte County appears to be significantly higher than rates noticed throughout California or the nation.

Riverside General Hospital-University Medical Center is a public hospital. Persons coming for care frequently have limited resources. They put off treatment until advanced disease finally forces them to seek care. Severity of illness statistics reveal that these patients have a significantly greater severity of illness than in other non-public hospitals. Based on these considerations it becomes clear that the death rate reported by HCFA requires closer analysis before conclusions on the quality of care can be reached.

Sincerely yours,

A handwritten signature in cursive script that reads "Dale B. Sparks, M.D.".

Dale B. Sparks, M.D.
Chief of Medical Staff
Riverside General Hospital-UMC

DBS:er

**CHILDREN'S HOSPITAL
OF SAN FRANCISCO**
A subsidiary of Northern California Health Center
Provider No. 05-0208

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for providing the opportunity to Children's Hospital of San Francisco to submit our written response to HCFA's mortality report for 1986. We are a non-profit, non-sectarian, tertiary acute care teaching hospital that serves the health care needs of infants, mothers and children, and adults of all ages, including some 11,000 members of Senior Security, Children's health protection plan for Medicare beneficiaries. Providing the best possible quality care to our patients is the hallmark of our 112 year history of service to our community.

In order to assure that our patients are receiving the highest level of quality care, Children's Hospital and its Medical Staff have in place a Quality Assurance Program which objectively looks at all aspects of patient care, as well as every death in our facility. In the course of this review process, the medical staff quality assurance committees evaluate the quality and appropriateness of the care provided to the patient. When problems are identified, they are referred to the medical staff leadership and/or administration for correction and resolution. This review process not only identifies problem areas but assists the hospital and the medical staff in recognizing opportunities to improve the care we are providing. Because of our commitment to the continuum of health care for all of our patients, the importance of this review process cannot be over-emphasized.

We have conducted a comprehensive review of your data and a comparison of our own records for the same period. After extensive review, we found that although there are minor discrepancies, which will be reported to you under separate cover, the data is generally accurate and correct and reflects that Children's Hospital of San Francisco overall actual mortality rate of 11% falls in the midpoint of the range of predicted mortality rate.

We would like to stress the importance of recognizing that mortality data is not a direct indicator of quality of care. The data does not distinguish severity of illness or the specialty services provided by an institution. We believe that these factors and the actual care provided to a patient must be evaluated by clinical practitioners according to medically established standards before true quality can be measured. This is and always has been the purpose of our internal hospital quality assurance program.

P.O. BOX 3805 • SAN FRANCISCO, CA 94119 / 3700 CALIFORNIA STREET • SAN FRANCISCO • 415/387-8700

CHILDREN'S HOSPITAL OF SAN FRANCISCO / CHILDREN'S HOSPITAL OF SAN FRANCISCO FOUNDATION / NORTHERN CALIFORNIA AMBULATORY HEALTH SERVICES / NORTHERN CALIFORNIA MEDICAL SERVICES, INC.

We strongly believe that our hospital-wide quality assurance program is a more valid and effective means of measuring quality of care than a complex statistical model which does not include a comprehensive review of severity of illness, complications and outcomes of disease process.

Sincerely,

A handwritten signature in dark ink, appearing to read "G. Robert Castle". The signature is fluid and cursive, with a long horizontal stroke extending from the end.

G. Robert Castle
Acting Chief Operating Officer

A handwritten signature in dark ink, appearing to read "Richard J. Cohen, M.D.". The signature is cursive and includes the letters "MD" at the end.

Richard J. Cohen, M.D.
Chief of Staff



Christian Hospital Medical Center

2224 Ruby Dr. • Perris, CA 92370 • (714) 657-7381

Administration Office

October 21, 1987

Department of Health & Human Services
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O.Box 26684
Baltimore, Maryland 21207

RE: Mortality Statistics
Medicare Patients, 1986

Dear Sirs:

Thank you for this opportunity to respond to the release of data on hospital mortality rate for 1986. Since receiving the report dated September 21, 1987, Christian Hospital Medical Center [CHMC] staff has had the opportunity to review the data.

The Quality Assurance Committee in the hospital has studied this data. The Director of Nursing has reviewed all cases in the category of cerebro vascular accidents.

CHMC is a 36 bed acute care facility, whose case mix includes many patients with major medical and surgical illness. We are a full service hospital offering care in speciality areas of ophthalmology, orthopedic surgery, otolaryngology, vascular surgery, cardiology, internal medicine, radiology, podiatry, urology, pathology, gynecology as well as general medicine and surgery.

On an on-going basis, appropriate clinical departments have always reviewed every mortality in our facility for appropriateness of care. In all cases, care was deemed appropriate and mortality was unavoidable.

Based on the comprehensive review of the data and the specific medical records it reflects, we are confident that you and any member of the public who requests a copy of our statistical information will be interested in our summary report.

It is noted that the overall mortality rate for CHMC is well within the range of predicted mortality rates.

The following summaries are findings by diagnostic category:

CA - CANCER

The predicated percentage of deaths in this category was reported to range from 8% - 44%; ours was 23%, which is well within the predicted range.

CE - CEREBRO VASCULAR ACCIDENTS

The predicted percentage of deaths in this category was reported to range from 15% - 44%; ours was 51%.

It should be noted that:

- * 95% of all of the patients and/or their families had requested that no heroic measures be taken to prolong the the patient's life ["No Code"].
- * 43% of the cases presented to the E.R. in a comatose condition requiring initiating of respiratory assistance on a ventilator.
- * 74% of the cases were admitted to the ICU and were thus in a critical condition on admission.
- * Only 37 patients were treated for CE and each mortality represents 5% of the total. One patient the principle diagnosis was possible CVA, respiratory arrest. Another patient was discharged from CHMC to a nursing home in a medically stable condition. CHMC does not know how the patients condition changed 8 days post discharge and we do not know what this patients ultimate cause of death was.
- * 85% of the patients were over 70 years old and 53% of the patients were over 80 years old .
- * Medicare patients treated in 1986 in CE accounted for only 5% of the Medicare patients treated at CHMC.

CE - GASTROINTESTINAL CATASTROPHIES

The range of predicted mortality rates in this diagnostic category was reported to be 3% to 35%; ours to be 14%, which is well within the predicted range.

GU - UROLOGIC DISEASE

The range of predicted mortality rates in this diagnostic category was reported to be 1% - 23%; and ours to be 3%, which is well within the predicted range.

GY - GYNECOLOGIC DISEASE

The range of predicated mortality rates in this diagnostic category was reported to be 0% - 100%; we had no deaths in this category.

HL - LOW RISK HEART DISEASE

The range of predicted mortality rates in this diagnostic category was reported to be 2% - 11%; ours to be 3%, which is well with the predicted range.

HM - SEVERE CHRONIC HEART DISEASE

The range of predicted mortality rates in this disgnostic category was reported to be 13% - 36%; ours to be 29%, which is well within the predicated range.

HS - SEVERE ACCUTE HEART DIEASE

The range of predicated mortality rates in this diagnostic category was reported to be 25% - 51%; ours to be 44%, which is well within the predicated range.

ME - METABOLIC/ELECTROLYIC DISTURBANCE

The range of predicated mortality rates in this diagnostic category was reported to be 7% - 40%; ours to be 12%, which is well within the predicated range.

OP - ORTHOPEDIC DISORDERS

The range of predicated mortality rates in this diagnostic category was reported to be 0% - 24%; ours to be 4%, which is well within the predicated range.

PN - PULMONARY DISEASE

The range of predicated mortality rates in this diagnostic category was reported to be 12% - 34%; ours to be 31%, which is well within the predicated range.

RN - RENAL DISEASE

The range of predicated mortality rates in this diagnostic category was reported to be 4% - 69%; ours to be 33%, which is well within the predicated range.

SE - SEPSIS

The range of predicated mortality rates in this diagnostic category was reported to be 11% - 82%; ours to be 60%, which is well within the predicated range.

TR - SEVERE TRAUMA

The range of predicated mortality rates in this diagnostic category was reported to be 2% - 23%; ours to be 3%, which is well within the predicated range.

The medical staff of CHMC, as has been their practice, will continue to review all mortality cases for quality and appropriateness of care utilizing criteria developed by the Joint Commission of Accreditation of Hospitals. Analysis of data from these criteria assures the continuance of optimum patient care standards.

Sincerely,



Wendy Becker
Administrator
WB/gn



Medicare Provider ID #050329

William L. Roper, M.D., Administrator
Health Care Financing Administration
Washington D.C. 20201

Dear Dr. Roper,

October 22, 1987

Thank you for this opportunity to respond to HCFA's 1986 Medicare mortality data for our hospital.

Our Director of Medical Records has verified that with minor exceptions, HCFA's data is accurate in its listing of deaths occurring at the hospital (those cases in which the date of discharge is the date of death). The minor inaccuracies are attached for your information.

Cases in which death occurred after discharge were more difficult to verify, as suggested in your letter accompanying the statistics. However, verification was accomplished where possible by our Utilization Review/DRG Coordinator.

Review of our hospital's actual mortality rates for each diagnostic category finds that our mortality rate was well within the predicted mortality range, and that there were no instances in which that range was exceeded. The nearest we came to the high end of the predicted range was in the cancer category, in which our mortality rate was 10 points below the high end of the predicted range.

Our facility practices 100% mortality review, bringing every case of death to the Peer Review table for medical staff review and discussion. All cases are reviewed for appropriateness, quality of care, and preventability of the death.

For those mortality cases in which death occurred after discharge, a review of the record for the last hospitalization was performed. An emphasis was placed on review for premature discharge, and there were no such cases defined. All of these cases reflected appropriate management and readiness for discharge. In 32% of those cases, the patient was considered terminal and the subsequent death was expected. The majority of the remaining 68% were discharged to an extended care facility or to the supervision of home health care for continued observation and care.

Although these mortality figures are not a direct representation of quality of care, Circle City Hospital does continue to assess the care provided, strives to provide the best care possible, and supports the principle of communicating appropriate and meaningful quality of care information to consumers.

Again, thank you for the opportunity to present this response. If you or anyone reviewing this material have additional questions, please do not hesitate to call me at (714) 735-1211.

Sincerely,
Julia Lynn, LVN
Julia Lynn, LVN,
Quality Assurance Coordinator

730 Old Magnolia Avenue, P.O. Box 310, Corona, California 92625-0310 (714) 735-1211

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.



Community Hospitals of Central California

Fresno & "R" Streets, Fresno, CA 93721 / P.O. Box 1232, Fresno, CA 93715, (209) 442-3996
James D. Helzer - President and Chief Executive Officer

October 23, 1987

William L. Roper, M.D.
Department of Health & Human Services
Health Care Financing Administration
The Administrator
Washington, D.C. 20201

Dear Dr. Roper:

This letter is in response to your Administration's planned release of mortality data on the three acute hospitals which make up the Community Hospitals of Central California. Our three acute hospitals, Clovis Community Hospital, Sierra Community Hospital, and Fresno Community Hospital and Medical Center have reviewed this data and your analysis regarding the specific mortality data on Medicare patients who were treated between January and December, 1986.

In response to the data presented about our three hospitals, we would like to make the following general comments about your analysis.

1. All of our facilities indicate normal ranges of mortality rates in the vast majority of the diagnostic categories compared to other hospitals in the nation. We are proud of our overall status in relationship to all causes of death among our Medicare patients during the 1986 calendar year.
2. We have reviewed each of the documents for our facilities in detail and have found small inaccuracies which deal with some of the diagnostic listings and also the period of time in which it was administered. In the case of Sierra Community Hospital, only 10 months during the 12 month period were actually recorded in the data reported in your findings. Indications also show that at Sierra Community Hospital several of the cases are of individuals who are on the average 80 years of age with a variety of secondary diagnoses such as diabetes, chronic pulmonary disease, emphysema, and renal failure; these are contributing factors to the mortality statistics indicated in your records.



BOARD OF DIRECTORS: Bud Richter, Chairman / Ken O'Brien, M.D., Vice Chairman / Lou Herwaldt, Vice Chairman / John Stoughton, Secretary / Elmer Nilmeier, Treasurer / Clifford Davis / Donald Fine / Gene Ford / Richard Ford / Reid Gromis / Ben Gutierrez / Joseph Levy / Kendall Manock / James Mayer / Wanda Rogers / Yoshito Takahashi / Edwin Wiens, M.D. / Joseph Woo, Jr., M.D.

Facilities: Clovis Community Hospital / Fresno Community Hospital & Medical Center / Sierra Community Hospital / Fresno Convalescent Hospital / Sierra Meadows Medical Service / Sierra View Convalescent Hospital



William L. Roper, M.D.
Page Two
October 23, 1987

3. Fresno Community Hospital and Medical Center, which is a major tertiary care center for the Central San Joaquin Valley, sees a high number of elderly and acutely ill patients. This results in our statistical mortality being higher in certain categories because outlying facilities transfer acutely ill patients to us because of our complete range of health care services.

It should also be mentioned that all of our hospitals continue to operate Quality Assurance Programs that monitor all patient data in all areas of medical and surgical specialties. Our three individual medical staffs have reviewed for appropriateness all of the cases outlined in your data and we will continue to strive for the highest possible quality of care available in the area.

In closing, we would hope that in the future releases of this data you would provide us with the individual hospital identification numbers, length of stay for each patient, the average age by diagnosis category and if this data could also be reported in alphabetical order by discharge date. This information would make it easier for our staffs to analyze the data and review its accuracy.

Thank you for your attention to our comments and if any additional information can be provided by our organization, please do not hesitate to contact me at your convenience.

Sincerely,

Melvin J. Wexler, Vice President
Marketing Strategy

MJW:jl



2701 SOUTH BRISTOL STREET
SANTA ANA, CALIFORNIA 92704
Phone: (714) 754-5454

October 28, 1987

Healthcare Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
PO BOX 26684
Baltimore, MD 21207

To Whom it May Concern:

Thank you for the opportunity to provide input into the mortality statistics of October 1, 1984 through September 30, 1986.

The Medical Staff at Coastal Communities Hospital routinely conducts an ongoing review of every mortality in our facility for the appropriateness and quality of care. The hospital specific data reported by HCFA was again reviewed by members of Hospital Administration, the Director of Utilization Review and Quality Assurance and the Director of Medical Records. With minor exceptions, the data submitted is accurate.

In one of the diagnostic categories, Severe Acute Heart Disease, the hospital's mortality rate fell outside of the range of the predicted mortality rate. The predicted range is 26-66%. Our percentage of deaths was 68% or 15 of 22 patients seen in this category.

It should be noted that:

1. The average age of the fifteen patients was 72.3 years. One patient was 58 years old, 5 years post triple bypass surgery with a steadily worsening condition. Per patient and family request, he was a "no code". The average age of six of the fifteen patients was 88.8 years.
2. Two of the fifteen patients were successfully treated and discharged from our facility with no apparent complications at the time of discharge.
3. The families in three cases requested a "no code".
4. Nine patients experienced one or more cardiac arrests during their hospitalization and did not respond to aggressive therapy.

We will continue to monitor all deaths on an ongoing basis in an effort to identify opportunities to improve care thru continuing medical education and peer review.

Thank you for the opportunity to review the statistical data from our hospital and industry norms.

Sincerely,

A handwritten signature in cursive script, reading "Elizabeth J. Starke". The signature is written in dark ink and includes a small flourish at the end.

Elizabeth Starke
Executive Director

ES:sh

Community Hospital of the Monterey Peninsula

Dear Dr. Roper:

October 26, 1987

The following information for Community Hospital of the Monterey Peninsula is to be attached to the Hospital's specific report which will be released in December for public disclosure.

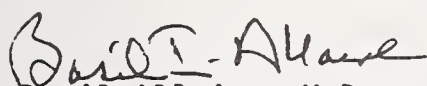
Community Hospital of the Monterey Peninsula is a 170 bed acute care facility, whose case mix includes many patients with major medical and surgical illnesses. We are a full service medical center offering care in specialty areas of oncology, major orthopedic services, as well as general medicine and surgery.

The Medical Staff conducts an intensive review of the medical record of every patient who expires at this facility regarding medical management and overall care. Mortality review is an ongoing process of the Quality Assurance program and peer review activities which are an integral part of the monitoring of the healthcare delivery system at this hospital. The Joint Commission on Accreditation of Hospitals recently bestowed on this facility a three year accreditation.

The Hospital's specific mortality data reported by HCFA indicated that Community Hospital exceeded the predicted mortality rate in only one category, Cerebrovascular Accidents. Our analysis of the 48 patients who died indicates that the average age of those patients was 80 and our review also showed that 27 died while hospitalized, 20 within 30 days after admission and 1 within one year after admission.

Thank you for giving us the opportunity to comment.

Sincerely,


Basil Allaire, M.D.
President
Medical Staff


Will Bishop
Vice President
Financial Services

William L. Roper, M.D.
Department of Health & Human Services
Health Care Financing Administration
The Administrator
Washington, D.C. 20201



COMMUNITY HOSPITAL OF SACRAMENTO

2251 HAWTHORNE ST. P.O. BOX 15521 SACRAMENTO, CA 95813 916/929-2333

October 19, 1987

Health Care Financing Administration
Department of Health and Human Services
Attention: HSQ-148-GNC P.O. Box 26676
Baltimore, Maryland 21201

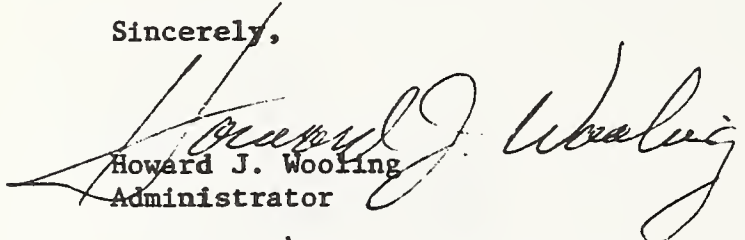
Community Hospital of Sacramento (Medicare Provider Number 050371) would like to respond to the 1986 Mortality Data Release with the following comments:

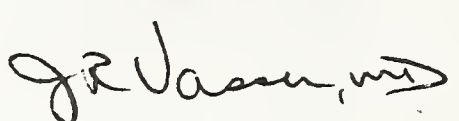
Dear Health Care Consumer:

Community Hospital of Sacramento is pleased to have been a part of the HCFA 1986 Mortality Data Release. Additionally we are pleased to note that our mortality statistics are well within the predicted norms and in many cases are less. This reflects our ongoing commitment to quality care. Our Medical Staff have always reviewed every mortality case for appropriateness of care and use this information as a continuous mechanism to meet and exceed quality care standards. We are proud of our demonstrated success in providing quality, individualized care.

We thank you for the opportunity to comment on this important document.

Sincerely,


Howard J. Wooling
Administrator


James R. Vasser, M.D.
Chief of Staff

HJW;JRV/jgl



**COMMUNITY
HOSPITAL**
AND REHABILITATION CENTER
OF LOS GATOS - SARATOGA

October 15, 1987

Medicare Provider
#050188

William L. Roper, M.D.
Administrator
Department of Health and Human Services
Health Financing Administration
Washington, D.C. 20201

Dear Doctor Roper:

Community Hospital and Rehabilitation Center of Los Gatos-Saratoga is commenting as follows regarding mortality information related to treatment of Medicare patients in 1986:

Community Hospital tends to be higher than the national average in the diagnostic category of cerebral vascular accidents because these patients are admitted to the acute medical/surgical facility with the intent to transfer to a free standing rehabilitation hospital as part of Community Hospital's campus.

Community Hospital is also higher than the national average in the categories of low risk heart disease, severe acute heart disease and pulmonary disease, due to rising acuity and increasing average age of patients.

Very Truly Yours,

Howard Classen
Chief Operating Officer

HC:bb:0584A

815 Pollard Road
Los Gatos, California 95030
(408) 378-6131



October 27, 1987

TO: William L. Roper, M.D., Administrator
Health Care Financing Administration

FROM: Larry Hood, Chief Executive Officer
Community Hospital, Santa Rosa (Provider Number 050291)

SUBJECT: Public Response to HCFA Mortality Data Release

Please find enclosed the public response to Community Hospital's data set for calendar year 1986.

Thank you for the opportunity to comment on this information.

COMMUNITY HOSPITAL



In affiliation with:
University of California
School of Medicine

October 26, 1987

Dear Health Care Consumer:

On behalf of the staff at Community Hospital, I would like to respond to the release of Health Care Financing Administration (HCFA) hospital-specific data for the period January - December 1986. Since receiving the report last month, the staff at Community Hospital has thoroughly reviewed the information presented and validates that it is accurate. The data reflect the Hospital's commitment to providing high quality care. Community Hospital is well within the expected range of mortality rates in each of the 17 disease categories.

Community Hospital is a 175-bed full service medical complex offering a wide range of outpatient and inpatient health care services. It is considered a referral center for the outlying areas of Sonoma County and the two rural counties to the north, Lake and Mendocino counties in the areas of major medical and surgical care, trauma, dialysis, pulmonary rehabilitation, obstetrics, neonatology and diagnostic procedures.

Community Hospital is also a teaching facility affiliated with the University of California offering state-of-the art family oriented care through its Family Practice Residency Program.

The Hospital's system for assuring that high quality care is provided encompasses all aspects of Hospital services. Specially trained nursing staff review each case at the time of admission and throughout the patient's stay to evaluate the type and level of services needed as well as to begin preparation for the patient and family needs after discharge.

The medical staff routinely reviews care as part of their ongoing quality monitoring program. This includes the review of all patient deaths, readmissions, complications and high risk procedures.

The relationship between ethical considerations and mortality rates was profoundly evident throughout the review of these cases. Many of the deaths occurred in patients who had been fully informed of their prognosis and who had communicated to their physician their wish to refuse heroic life-saving measures. In instances when patients were unable to speak for themselves, the families' wishes were given great consideration.

3325 CHANATE ROAD
SANTA ROSA, CALIFORNIA 95404
TELEPHONE: (707) 544-3340

LARRY E. HOOD
Administrator

FRANK D. DORNFEST, M.D.
Medical Director
Director Family Practice Program

CA 114.1



Letter: Response to HCFA Mortality Data
Page Two.

The data presented by HCFA show that Community Hospital is well within the expected range of mortality rates in all 17 disease categories. The mortality rates in most categories lie near the middle or lower end of the range, indicating that the number of deaths in these categories at Community Hospital is consistent with national trends.

The two disease categories in which the percentage of deaths lies near the high end of the range deserve further explanation.

Cancer - The predicted range of deaths in this category is 12% - 36%. The actual mortality rate is 31%, representing 17 deaths. It should be noted that:

- Most of the patients were in advanced stage of the disease and were admitted primarily for pain management rather than therapeutic treatment;
- 16 of the 17 deaths occurred in patients who requested no life prolonging treatment.

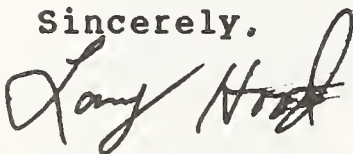
Sepsis (blood poisoning) - The predicted range for deaths in this category is 12% - 61%. The actual mortality rate is 46%, representing 6 deaths. It should be noted that:

- Most of the patients had severe underlying illnesses that in and of themselves could be life-threatening;
- 2 of the 6 deaths occurred in patients who requested no life prolonging treatment.

In summary, data submitted by HCFA have been carefully considered. The data, as one of many indicators of quality care, are well within the expected range of mortality rates for our patient population. We concur with the information presented and feel it supports and reflects the staff's commitment to providing high quality health services.

Thank you for the opportunity to comment on this information.

Sincerely,



Larry Hood
Chief Executive Officer

cc: Sonoma County Medical Society

COMMUNITY HOSPITAL OF GARDENA

19 October 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
Baltimore, Maryland, 21207
Attention: William M. Roper, M. D.
Administrator

Dear Doctor Roper:

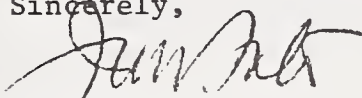
We would like to have the following information for Community Hospital of Gardena be attached to our hospital specific report of selected mortality information scheduled to be published in December 1987 about all short term acute care hospitals which treated Medicare patients in 1986.

It is to be noted that in all sixteen diagnostic categories, for this particular period in time, our actual death rate falls within the range of predicted mortality data given the characteristics of the patient mix of patients admitted and treated in our hospital, except in one category which is less than the predicted rate.

By counting all deaths occurring within 30 days from the date of discharge, the hospital may be "credited" with deaths that are unrelated to the original condition of the patient that was under treatment. Our Utilization Review physicians assure the medical stability of the patient at discharge through our concurrent monitoring system during the patient's hospitalization.

Furthermore, our Medical Staff committees have been diligent in their review of medical records of every death in our facility on an ongoing basis. This is done to assist in identifying opportunities to improve care, as well as to assure that the care given to our patients are of the highest quality.

Sincerely,



Jim Sato
Administrator

1240 West 155th Street
Gardena, California 90247
213-525-5530

An Affiliate of

HEALTHTRUST
INC. The Hospital Company

CA 115

CORONA COMMUNITY HOSPITAL



Eight Hundred South Main Street • Corona, California 91720-3354
(714) 737-4343 • (714) 688-0093

Corona Community Hospital's primary concern is to ensure that our patients receive quality care. We do this by reviewing patient care in all our departments on an ongoing basis. These meetings cover quality control, infection control, utilization review and credentialing of physicians. If a problem is identified, it is dealt with promptly and corrective action taken to resolve it.

The mortality data released by the Health Care Financing Administration (HCFA) does not measure hospital performance or confirm whether or not quality problems exist. What it does, through its comparisons of actual and predicted mortality rates, is suggest areas to be reviewed. The mortality data released on Corona Community Hospital fell into the ^{predicted} ~~normal~~ range in all categories but one. In the category of gastrointestinal disease, there were 13 deaths out of 58 cases reviewed, resulting in a 22% mortality rate, six points above the ^{predicted} ~~normal~~ range.

In carefully reviewing the thirteen cases involved in the study, physicians on the hospital's medical staff found that two of the deaths occurred after discharge. One of these deaths was the result of chronic renal failure which was completely unrelated to the gastrointestinal problem for which the patient was admitted. The other cause of death is unknown, but based on the patient's most recent hospital medical record, it was felt that the GI condition was not contributory to death. Of those patients that did die in the hospital, two involved proven carcinoma in which death was considered imminent and several others had multiple medical problems.

Taking these factors into consideration, the medical staff is confident that there is nothing to indicate any problems with quality of care in this area.

It should be noted, finally, that the overall mortality rate for the hospital is well within the ~~normal~~ ^{predicted} range.

President
I. Byron Streifling

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Calvin Hanson
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A Not For Profit
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Medical Center



COVINA VALLEY COMMUNITY HOSPITAL

845 N. LARK ELLEN AVENUE, WEST COVINA, CA 91791 • (213) 339-5451

October 12, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Admin.
Health Standards & Quality Bureau
Hosp. Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

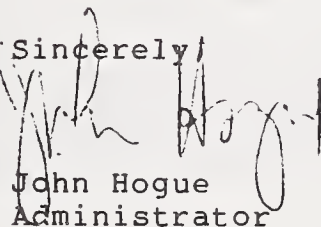
Dear Dr. Roper,

After reviewing the Mortality Reports by HCFA. Please be informed of the following:

- 1) The mortality numbers reported for this hospital are correct.
- 2) Mortality review is performed 100% as a part of this hospital's quality control program.
- 3) This hospital welcomes the opportunity to discuss the quality of care and services and the principle of communicating appropriate and meaningful quality of care information to consumers.
- 4) Covina Valley Community Hospital is in an area of heavy concentration of convalescent hospitals. Therefore, the ages in the mortality report are in the elderly groups.

Should you have any questions please call me at 818-339-5451, ext. 3500.

Sincerely,



John Hogue
Administrator

JH/so
cc:

Rachel Heredia
Medical Records Director

DANIEL
FREEMAN
MARINA
HOSPITAL

A Carondelet Health Care Corp.
4650 Lincoln Blvd
Marina del Rey, CA 90292
(213) 823-8911



October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Dear Dr. Roper:

According to the data published by the Health Care Financing Administration, the mortality rates of Daniel Freeman Marina Hospital fall within the predicted ranges in every category. When a nationally recognized severity index system is applied, the hospital's percentages are even more acceptable.

We are proud of the quality assurance program in use at Daniel Freeman Marina Hospital. To make the published statistics more meaningful to the public and more useful to hospitals, our recommendation is that HCFA use a clinical severity index in its future analyses.

The mortality rates of Daniel Freeman Marina Hospital fall within HCFA's predicted ranges in every category. Further, in nine of the 15 diagnostic categories, we are in the lower half of the predicted range.

It should be noted that Daniel Freeman Marina Hospital has a very active Emergency Department and serves a high density residential area consisting of a high elderly population base.

In reviewing mortality data, it must be recognized that the medical treatment received is only one of the many factors that impact patient outcome. While HCFA has done an excellent job in considering some of these factors, such as age, sex, some related illnesses and prior hospitalizations, it has been impossible, with the information available to HCFA, to include all variables within the predicted (published) ranges.

We have done a complete review of the charts of every patient who died at our hospital in calendar year 1986. Our purpose is to

identify additional characteristics of our patient population that may have influenced our mortality statistics. Items identified that may be more specific to our patient population and were not available to HCFA for inclusion in their statistical model make interpretation of the published data more meaningful.

Furthermore, these items point out the high standards of our quality assurance program. Most notably, through the application of a nationally recognized severity of illness clinical scale (Systemetrics, a scale also used by the University of California hospital system), we find that, upon admission, our patient population has a high severity of illness.

The Systemetrics index categorizes patients from 1.0 to 4.0, with 1.0 being patients admitted for conditions with no complications, 2.0 patients admitted with problems limited to an organ or system, 3.0 with multiple site involvement and poor prognosis, and 4.0 being death.

Due to the overall limited size of the patient population at Daniel Freeman Marina Hospital, no one category lends itself to rigorous statistical analysis. However, we are within the predicted range in every category.

Nevertheless, we chose to look at two categories where we fell within the upper end of the range. These categories were Severe Acute Heart Disease and Cerebral Vascular Accidents. Review of the individual mortality records reveals a very high Severity of Illness upon admission for Severe Acute Heart Disease -- 3.8 on the Systemetrics scale. This severity can further be demonstrated in the fact that 12 of the 19 severe acute heart disease patients who died, did so, on the average, less than 24 hours after admission. The same review was done for Cerebral Vascular Accidents and the severity index upon admission was 3.6. Of course, this information was impossible for HCFA's statistical model to recognize.

Daniel Freeman Marina Hospital recognizes the public's right to expect the federal government to provide information based upon analysis of the raw data available. We also recognize our obligation to make the interpretation of that data more meaningful by supplementing the government's raw data with our hospital- and patient-specific characteristics. Having done this, and finding that we fall within the predicted ranges, we assert that our commitment to quality health care and our quality assurance program are working well.

We also recognize that quality judgments can only be made on the basis of a complete review of all medical charts. Daniel Freeman Marina Hospital has done this, and continues to do this, for

every mortality. The charts are reviewed by an elaborate set of quality assurance screens in a continuing effort to maintain and improve patient care. We stand behind our quality assurance program and welcome the opportunity to discuss the quality of care delivered in our hospital.

Through these types of joint efforts, we will be able to continue to provide a high quality, cost effective level of health care while at the same time identifying areas of public concern and possible improvement. We do, however, feel that the public in general, and this type of effort in particular, could be more fully served if HCFA and MediCare adopted a clinical severity index rating system. This information would thus be more meaningful to the public and more useful to hospitals.

Respectfully,



Stephen L. Packwood
Administrator



Martin Krell, M.D.
Chief of Staff

Daniel Freeman Marina Hospital
Medicare Provider #050559



October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Dear Dr. Roper:

According to the data published by the Health Care Financing Administration (HCFA), the mortality rates of Daniel Freeman Memorial Hospital fall at the center of the predicted ranges. When a severity index is applied, the hospital's percentages are even more acceptable.

To ensure that our health care standards remain high, the quality assurance program at Daniel Freeman Memorial Hospital reviews every medical chart of every patient admitted to our hospital.

To make these statistics more meaningful to the public and more useful to hospitals, our recommendation is that HCFA use a clinical severity index in its future analyses.

The mortality rates of Daniel Freeman Memorial Hospital stand at the midpoint of HCFA's predicted ranges. Further, in 11 of the 16 categories, we are in the lower half of the predicted range.

It should be noted that Daniel Freeman Memorial Hospital serves an unusually high number of elderly patients, in a referral setting, most of whom have a very high severity of illness at the time of admission.

We have done a complete review of the charts of every patient who died at our hospital in calendar year 1986. Our purpose was to identify additional characteristics of our patient population that may have influenced our mortality statistics.

Furthermore, the items identified point out the high standards of our quality assurance program. Most notably, through the application of a nationally recognized severity of illness clinical scale (Systemetrics, a scale also used by the University of California hospitals), we find that, upon admission, our patient population has a high severity of illness. The

Systemetrics clinical index categorizes patients from 1.0 to 4.0, with 1.0 being patients admitted for conditions with no complications, 2.0 for patients admitted with problems limited to a organ or system, 3.0 designated for patients with multiple site involvement and poor prognosis, 4.0 being death.

The only category in which we fall outside of the predicted range is for sepsis. Chart review of these patients upon admission reveals an overall severity index of 3.28, with 31.8% of the patients approaching the maximum rating of 4.0. In addition, seven of the patients died within an average of the first 10 hours of admission. Of course, this information was impossible for the HCFA statistical model to recognize.

In addition, at least three patients died of underlying disease for which sepsis was a complication. In two of these cases, the other diseases were not considered in the HCFA statistical model, once again skewing the data toward the high side of the predicted range. Furthermore, it should be noted that this elderly group of patients (average age greater than 81) all entered the hospital with their infection and in no case was mortality associated with a hospital-acquired infection. This statistic speaks very well for our infection control program.

In the same regard, the data for cancer mortality is impacted by social and demographic variables not considered in the HCFA statistical model. Daniel Freeman Memorial Hospital is a major cancer center, serving a large referral base for all cancer patients including patients requiring terminal care. This is reflected in the average age of 75.3 years for the patients in the mortality group. If the 48 patients requiring terminal care are subtracted out of data base, the result is a mortality rate of 15.3%, which is far below the predicted range of 20-36%.

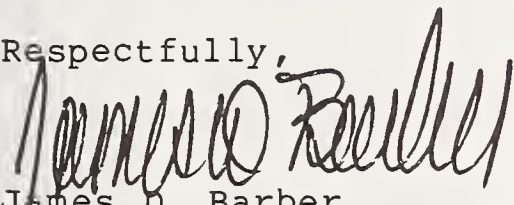
Daniel Freeman Memorial Hospital recognizes the public's right to expect the federal government to provide information based upon analysis of the raw data available. We also recognize our obligation to make the interpretation of that data more meaningful by supplementing the government's raw data with our hospital and patient-specific characteristics. Having done this, and finding that we have few significant deviations from the predicted rates, we assert that our commitment to quality health care and our quality assurance program are working well.

We recognize that quality judgments can only be made on the basis of a complete review of all medical charts. Daniel Freeman Memorial Hospital has done this, and continues to do this, on a 100% concurrent basis. Every chart of every patient admitted to our hospital is reviewed by an elaborate set of quality assurance screens in a continuing effort to maintain and improve patient care. We stand behind our quality assurance program and welcome

the opportunity to discuss the quality of care delivered in our hospital.

Through these types of joint efforts, we will be able to continue to provide a high quality, cost effective level health care while at the same time identifying areas of possible improvement. We do, however, feel that the public in general, and this type of effort in particular, could be more fully served if HCFA and MediCare adopted a clinical severity index rating system. This information would thus be more meaningful to the public and more useful to hospitals.

Respectfully,


James D. Barber
Administrator


Arthur Schapiro, M.D.
Chief of Staff

Daniel Freeman Memorial Hospital
Medicare Provider #050267



**Desert
Hospital**

October 28, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
Post Office Box 26684
Baltimore, Maryland 21207

To Whom It May Concern:

Thank you for the opportunity to respond to the current HCFA mortality data release.

A committee of individuals representing the Medical Staff, Quality Assurance, Medical Records and Administration has reviewed the data for Desert Hospital as compared with the HCFA predicted values for our specific patient population. We are pleased that in all categories our death rates are well within the predicted ranges.

Because of our interest in making this information useful to us, two diagnostic categories were selected for additional review - Metabolic/Electrolyte Disturbances and Severe Acute Heart Disease. The result of that review is as follows:

1. Metabolic/Electrolyte Disturbances

- o All twelve (12) deaths were reviewed
- o The average age of the patient was 81.4 years
- o All patients were admitted with dehydration which put them into this diagnostic category, however, ten patients were actually suffering from malignancies and in their terminal stages.
- o The two other patients, ages 87 and 91, experienced multiple system failures.
- o There was no indication of inappropriate care for any of these terminally ill patients.

2. Severe Acute Heart Disease

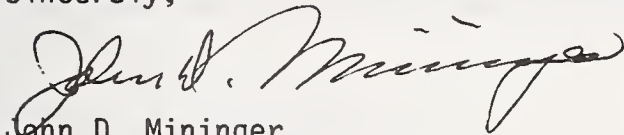
- o It should be noted that this category reflects one of the major service centers of our facility - Cardiology
- o All forty-one (41) deaths were reviewed
- o A clear majority of these patients (88%) had a heart attack outside the hospital and were brought to the hospital Emergency Department in an acute state.
- o Three patients died following discharge, in stable condition, from Desert Hospital
- o There was no indication of inappropriate care for any of these very acutely ill patients.

In addition to this analysis, anyone reviewing our statistics will be interested to know that:

- o Desert Hospital is a Regional Trauma Center. All trauma cases within a fifty mile radius are brought here because of this designation. Typically, these patients are much sicker than the average when they arrive at the hospital. This should be kept in mind when reviewing the statistics.
- o All deaths at Desert Hospital are reviewed through our Medical Staff peer review function. Review of quality and appropriateness of care is done by multidisciplinary groups of practicing physicians. We put a great deal of energy into peer review and are proud of our efforts.

Again, thank you for the opportunity to comment on the statistics you will release on Desert Hospital. If you or anyone receiving this material have any questions, please contact me at 619/323-6315.

Sincerely,



John D. Mininger
Executive Vice President

/cv



Doctors Medical Center

1441 Florida Ave., P.O. Box 4138, Modesto, Calif. 95352/Phone (209) 578-1211

Federal ID# 94-1692567

October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
P. O. Box 26684
Baltimore, Maryland 21207

Dear Mr. Roper:

In response to the HCFA Mortality Data Release, there appears to be a miscalculation in Doctors Medical Center's actual mortality rate for cerebrovascular accidents. Upon review of your numbers, seventy two (72) cases were reviewed with twenty-eight (28) of the cases being deaths. This calculates to a 39% mortality rate, which is within the average range. Your data quotes it as being 42%.

Doctors Medical Center offers a full range of acute care services. Although patients experiencing a cerebral vascular accident carry a high percentage of risk for mortality, those admitted to DMC have the benefit of not only medical expertise but swift surgical intervention if warranted.

The percentage of cases surveyed for 1986, with the final outcome of death within 30 days, does not reflect the severity factor found on review of the cases. Over half of the patients in the survey experienced bleeding or infarcts so severe that on admission, survival was not anticipated. Three patients who expired after discharge had severe renal and/or severe hypertensive disease. One third of the patients in the findings had surgery. Five of these patients had cardiac complications which led to their demise. Two others succumbed to pneumonia.

Given the scope of care provided at DMC, it is not unanticipated that our rates in areas with high risk of mortality will be in the high end of the range.

Sincerely,

Steve Mitchell
Administrator

SM/so/0846D

A National Medical Enterprises Organization

Fully accredited by the Joint Commission on Accreditation of Hospitals

MICHAEL D. KERR
CEO / Executive Director



DOCTORS HOSPITAL OF LAKEWOOD

A National Medical Enterprises Health Care Center

3700 East South Street ■ Post Office Box 70 ■ Lakewood, California 90712

Telephone: (213) 531-2550

Provider # 050581

October 23, 1987

Health Care Financing Administration
Health Standards Bureau
Hospital Mortality Information
P.O. Box 26684,
Baltimore, Maryland 21207

To the Citizens of our Community:

Thank you for this opportunity to respond to the release of data on Doctors Hospital of Lakewood mortality rates for the calendar year 1986. Our statistics have been validated and with some exceptions, the data are accurate.

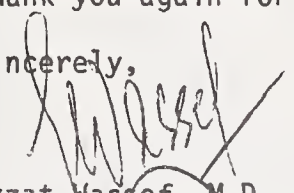
While we believe that this information is useful, until additional statistical measures are developed to deal with complex issues such as severity of illness, we can not and do not recommend the use of the information by itself to make judgments about the quality of care in an individual hospital or to make comparisons among hospitals.

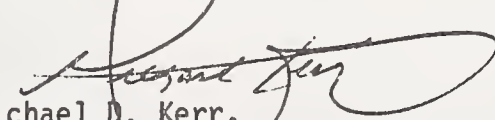
We are pleased however, to note that our actual mortality rates at Doctors Hospital of Lakewood are well within the range predicted by the Health Care Financing Administration.

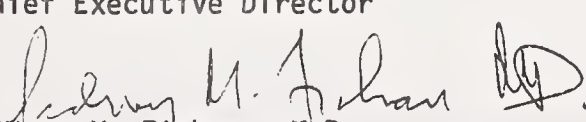
The Medical Staff of Doctors Hospital of Lakewood conducts an intensive review of the medical record of every patient who expires at this facility regarding medical management and overall care. Mortality review is an on-going process and peer review activities are an integral part of the monitoring of the healthcare delivery system at this hospital. Trending analysis from these reviews is a constant endeavor to assist in identifying opportunities to improve care so that we may continue to provide the citizens of our community with the highest and most efficient medical care available.

Thank you again for the opportunity to present this response.

Sincerely,


Ezzat Wassef, M.D.,
Chief of the Medical Staff


Michael D. Kerr,
Chief Executive Director


Sidney M. Fishman, M.D.,
Chairman, Quality Assurance Committee

Accredited by the Joint Commission on Accreditation of Hospitals

EW/1

CA 134

MICHAEL D. KERR
CEO / Executive Director



DOCTORS HOSPITAL OF LAKEWOOD

A National Medical Enterprises Health Care Center

3700 East South Street ■ Post Office Box 70 ■ Lakewood, California 90712

Telephone: (213) 531-2550

Provider # 050581

October 22, 1987

Health Care Financing Administration
Health Standards Bureau
Hospital Mortality Information
P.O. Box 26684,
Baltimore, Maryland 21207

To the Citizens of our Community:

① Thank you for this opportunity to respond to the release of data on Doctors Hospital of Lakewood mortality rates for the calendar year 1986. Our statistics have been validated and with some exceptions, the data are accurate. While we believe that this information is useful, until additional statistical measures are developed to deal with complex issues such as severity of illness, we can not and do not recommend the use of the information by itself to make judgments about the quality of care in an individual hospital or to make comparisons among hospitals.

④ The Medical Staff of Doctors Hospital of Lakewood conducts an intensive review of the medical record of every patient who expires at this facility regarding medical management and overall care. Mortality review is an on-going process and peer review activities are an integral part of the monitoring of the healthcare delivery system at this hospital. Trending analysis from these reviews is a constant endeavor to assist in identifying opportunities to improve care so that we may continue to provide the citizens of our community with the highest and most efficient medical care available.

Thank you for the opportunity to present this response.

Sincerely,

Ezzat Wassef, M.D.,
Chief of the Medical Staff

Michael D. Kerr,
Chief Executive Director

Sidney M. Fishman, M.D.,
Chairman, Quality Assurance Committee

CA 134.1

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MICHAEL D. KERR
CEO / Executive Director



DOCTORS HOSPITAL OF LAKEWOOD

A National Medical Enterprises Health Care Center

3700 East South Street ■ Post Office Box 70 ■ Lakewood, California 90712

Telephone: (213) 531-2550

Provider # 050581

October 22, 1987

Health Care Financing Administration
Health Standards Bureau
Hospital Mortality Information
P.O. Box 26684,
Baltimore, Maryland 21207

To the Citizens of our Community:

Thank you for this opportunity to respond to the release of data on Doctors Hospital of Lakewood mortality rates for the calendar year 1986. Our statistics have been validated and with some exceptions, the data are accurate.

- ③ We are pleased, ^{however} to note that our actual mortality rates at Doctors Hospital of Lakewood are well within the range predicted by the Health Care Financing Administration.

The Medical Staff of Doctors Hospital of Lakewood conducts an intensive review of the medical record of every patient who expires at this facility regarding medical management and overall care. Mortality review is an on-going process and peer review activities are an integral part of the monitoring of the healthcare delivery system at this hospital. Trending analysis from these reviews is a constant endeavor to assist in identifying opportunities to improve care so that we may continue to provide the citizens of our community with the highest and most efficient medical care available.

Thank you for the opportunity to present this response.

Sincerely,

Ezzat Wassef, M.D.,
Chief of the Medical Staff

Michael D. Kerr,
Chief Executive Director

Sidney M. Fishman, M.D.,
Chairman, Quality Assurance Committee

EW/1

CA 134.2



D O C T O R S
H O S P I T A L

DATE: October 23, 1987

TO: Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Division
P. O. Box 26684
Baltimore, Maryland 21207

FROM: Doctors' Hospital of Pinole, Pinole, CA 94564

SUBJECT: HCFA Mortality Data Release

Thank you for the opportunity to respond to the data on hospital mortality rates.

Since receiving the report, Doctors' Hospital of Pinole has taken the opportunity to analyze the data. The Director of the Medical Record Department has validated the data with few minor exceptions and finds the report is a reflection of the statistics for our facility for Medicare patients.

We think you and any member of the public who requests a copy of our mortality information will be interested in the following findings:

In reviewing the statistics, it is apparent that the actual mortality rate at Doctors' Hospital of Pinole is below the mid-range of predicted mortality rates in 14 of the 17 categories listed, and below the high-range in 16 of the 17 categories.

In the Diagnostic Category of Cancer, our actual mortality rate was 24%, compared to mid-range of 23.5% for the predicted mortality rate. The average age in this category was 75 years of age, with 13.6% having a major surgery performed.

In the Diagnostic Category of Severe Acute Heart Disease, our actual mortality rate was 40% compared to mid-range of 38.5% for the predicted mortality rate. Five of the cited patients in this category had an acute myocardial infarction and one patient expired as a result of a cardiac arrest. There were no major surgeries listed in this category. The average age in this category was 75 years. Admissions occurred at an advanced stage of a patient's disease.

The Diagnostic Category of Gastrointestinal Catastrophy revealed Doctors' Hospital with a 43% actual mortality rate compared to a predicted high mortality rate of 38%. Review of the records and data of the patients in this category revealed the average age of the patient to be 81 years with an average length of stay of 9 days. Surgery for four of the patients in this category included a hemicolectomy for acute vascular insufficiency of the intestine, an intestinal manipulation for acute vascular insufficiency of the intestine, a gastroenterostomy for an intestinal obstruction, and an exploratory laparotomy for peritonitis. One patient received dialysis for an acute liver disease and

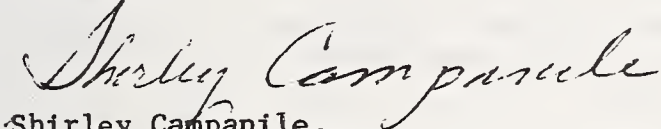
HCFA MORTALITY DATA RELEASE - Continued

the remainder of these acutely ill patients received conservative treatment.

The Medical Staff at Doctors' Hospital of Pinole reviews the record of every death at this facility. The findings of the record review continue to reveal the provision of a high standard of quality care for our patients.

Thank you again for the opportunity to respond on our review of this data. If you have additional questions, please call me at (415) 724-5000.

Sincerely.


Shirley Campanile,
Associate Administrator

c: National Medical Enterprises
Divisional Senior Vice President

lp/MedRec

CA 136.1



DOMINGUEZ MEDICAL CENTER

A SUBSIDIARY OF NATIONAL MEDICAL ENTERPRISES, INC.

LORRAINE P. AUERBACH
CHIEF EXECUTIVE OFFICER

October 20, 1987

Mr. William L. Roper, M.D.
Administrator
Department of Health & Human Services
Health Care Financing Administration
Washington, D.C. 20201

RE: HCFA MORTALITY DATA
RELEASE 1986

Dear Dr. Roper:

Thank you for this opportunity to respond to the release of data on the hospital mortality rate for year ending 1986.

Since receiving the report, a number of people at Dominguez Medical Center have had an opportunity to review the data:

- . We have validated with minor exception HCFA's data is accurate and is a reflection of statistics at our facility.
- . In conjunction with our Resource Management Department, every death chart has been reviewed in each major diagnostic category.
- . The Medical Staff Utilization Review Committee and several Utilization Physician Advisors' reviewed screens and charts that fell into these categories.

In addition to this specific review, on an ongoing basis, our Medical Staff Department reviews all deaths and all clinical activity. These charts have therefore all been previously reviewed by medical staff and have been found to be appropriately managed.

Based on a comprehensive review of HCFA's data and the specific medical record which it reflects, we think the members of the public who request a copy of the statistical information may be interested in the following information.

It is to be noted that Dominguez Medical Center has continued to remain well in the range of predicted mortality. The following summarizes our findings:

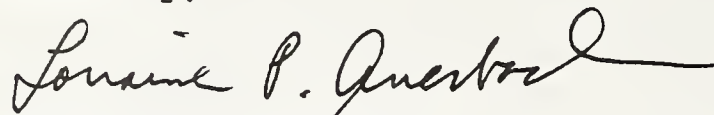
- . In the Major Diagnostic Category of Cancer: We were in the predicted mortality range, even though our patients are of advanced age and most were admitted through the Emergency Department or from a nursing home with multiple complications. This includes those patients that were discharged to a lower level of care with a terminal disease.
- . In the Major Category Cerebral Vascular Accidents: We were in the predicted mortality range even though this is classified as a high severity of illness. Again, our general population of patients are of ages greater than the average and often present with multiple complications.
- . In the Major Diagnostic Category Severe Acute Heart Disease: Although, as a community hospital we have many cardiac patients with multi-system problems, we have still fallen well within the predicted range.
- . In the Major Diagnostic Category of Sepsis: Our statistics fell in the middle of the range of the predicted mortality rate even though many of our patients come from nursing homes with the multicomplikations seen in the aged.

Based upon our review of the data of the calendar year 1986, Dominguez Medical Center has taken the following steps:

- . We have shared the significant findings with the Medical Staff so they will be able to respond to any questions their patients may ask.
- . The Medical Staff will continue its review of all deaths in the facility, they will review deaths that are included in your data so they may be prepared to assist us responding to request for information as data is released by HCFA.
- . Our Quality Assurance Program has been recognized as a model for hospitals of our size and with our type of patients, our physicians, nurses and administration vigilantly monitor the care being provided in the areas where emphasis is high in technology and where deaths appear higher even though they are still in the predicted range of mortality rate.

Again, thank you for this opportunity to present this response. If you, or anyone receiving this material, have additional questions, please do not hesitate to call me at (213) 639-5151.

Sincerely,

A handwritten signature in cursive script, reading "Lorraine P. Auerbach". The signature is fluid and extends to the right with a long horizontal stroke.

Lorraine P. Auerbach
Executive Director

LPA/cl



Downey
Community
Hospital

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October 21, 1987

William L. Roper, M.D.
Administrator
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH & HUMAN SERVICES
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for this opportunity to respond to the release of data on hospital Medicare mortality rates for January 1, 1986 through December 31, 1986. Since receiving the report dated September 21, 1987, Downey Community Hospital has had an opportunity to review the data.

The Risk Manager at our hospital has determined that the data is accurate, and has reviewed all of these cases.

In addition, all mortality cases are reviewed concurrently by administrative and medical staff members for appropriateness of care and accuracy of coding..

We were pleased to note that the Health Care Financing Administration's focus on severity of illness and method of tabulating mortality data shows our hospital in a favorable light, well within the predicted range of mortality in fifteen categories including the overall number of deaths.

We fall outside the predicted range in only one category, Severe Acute Heart Disease, at 51% compared to a predicted range of 0-49%. Our findings are summarized as follows:

- ° There were a total of 79 patients who fell into this category. Of these, 40 were mortality cases.
- ° Of the 40 mortality cases, 29 were paramedic transports. Of these 29, 21 had experienced cardio-respiratory arrest or were in shock prior to their arrival in Emergency department. They were treated by A.C.L.S. protocol.
- ° Of the 40 cases, 19 survived one day or less despite aggressive treatment.

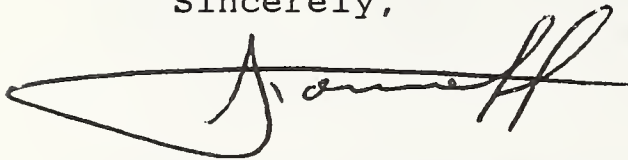
Dr. Roper
October 21, 1987
Page Two

- ° Of the 40 cases, 9 had a terminal illness in addition to heart disease; these include cancer, stroke, and pneumonia.
- ° In 25 of these 40 cases, it was requested that no further resuscitation efforts be made.
- ° An additional 10 of these 40 patients received resuscitation efforts before families were available for discussion of this issue.
- ° Five of the 40 received resuscitation efforts despite clinical diagnosis of massive heart attacks.

In summary, Downey Community Hospital is one of the most active paramedic base stations in Los Angeles County. We plan to continue this excellent program. We will also continue our ongoing review of every death to ensure that we are providing a consistently excellent standard of care to our patients and our community.

Thank you once again.

Sincerely,

A handwritten signature in black ink, appearing to read "A. Korneff", with a large, sweeping horizontal stroke extending to the left.

Allen R. Korneff
Chief Executive Officer

ARK:tm

EL CAMINO HOSPITAL
2500 GRANT ROAD, P.O. BOX 7025
MOUNTAIN VIEW, CA 94039-7025
415-940-7000



October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health & Human Services
Washington, DC 20201

Dear Dr. Roper:

Thank you for the opportunity to respond to the release of the 1986 HCFA mortality data on Medicare patients treated at El Camino Hospital.

We are pleased that the actual mortality rates at El Camino Hospital for all diagnostic categories were within the predicted ranges. This confirms the widespread impression that the quality of care at El Camino is excellent.

The report has been reviewed and confirmed by the Director of Quality Assurance, the Chief of the Medical Staff, Administrators, and the Director of the Medical Record Department.

In addition to review of reported statistical data such as the mortality rates, El Camino Hospital has an active, comprehensive and integrated Quality Assurance program to review quality of care on an individual basis. Every death in the hospital is thoroughly reviewed by the appropriate medical staff department, as well as by the Quality Assurance Coordinator.

This report includes data on some deaths that occurred after discharge. El Camino Hospital has a number of programs and services to help ensure that appropriate resources are available to patients following discharge. In 1987, the hospital established a home health agency and has an eleven-member Continuing Care Department available to every patient and family regarding community and home care services.

El Camino also has a professional Human Support Department to provide support and assistance to patients and family in managing the emotional aspects of hospitalization. A full-time chaplain and volunteers of all faiths offer spiritual support to patients in the hospital and at skilled nursing facilities to which they may be discharged.

OPERATED FOR THE BENEFIT OF EL CAMINO HOSPITAL INSIST

William L. Roper, M.D.
Administrator, HCFA
October 27, 1987
Page 2

Although we appreciate and recognize the value of the report for our internal quality assurance program, we are seriously concerned about the possible misinterpretation of the report when it is released to the public. In particular, since the range of predicted mortality is different for each hospital, it will be very difficult for the general public to make comparisons among hospitals. For example:

	<u>Hospital A</u>	<u>Hospital B</u>
Predicted Mortality Rate	10-20%	15-25%
Actual Mortality Rate	10%	15%

Both hospitals would be at the low end of the predicted mortality rate, yet the public could assume that Hospital B has a higher mortality rate.

Further, it is unlikely that the public is aware of the complexity of the factors that determine predicted mortality rates for individual institutions; e.g., severity of patient illness, multiple diagnoses, and patient age. Also, the statistics do not differentiate surgical and medical patients.

Consequently, we expect that the public will have many questions about the data and we will welcome the opportunity to answer those pertaining to El Camino Hospital.

Sincerely,


Neilson S. Buchanan
Chief Executive Officer

NSB/mcr



Feather River Hospital
5974 Pentz Road
Paradise, CA 95969
(916) 877-9361

October 23, 1987

To Whom It May Concern:

Attached you will find Feather River Hospital's response to HCFA's release of mortality statistics. Though our hospital has fallen within the "predicted range" in all diagnostic categories, we request that the mortality data for Diagnostic Categories (GU) Urologic Disease (1) case, (ME) Metabolic Disturbances (1 case), (TR) Trauma (1 case) and (SE) Sepsis (2 cases) be excluded because the raw numbers of cases are so low in each of these categories that there is a risk of breaching confidentiality of either the physician, the patient, or both.*

Thank you for this consideration.

* Appendices 1, Federal Register April 17, 1985.

A Member of
Adventist Health
System-West

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Joint Commission
on Accreditation
of Hospitals



Feather River Hospital
5974 Pentz Road
Paradise, CA 95969
(916) 877-9361

October 23, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

To Whom It May Concern,

Feather River Hospital, Provider # 050225 is pleased to have this opportunity to respond to HCFA's current release of data on specific hospital mortality rates for 1986.

Feather River Hospital is a 125 bed acute care hospital. We are located in Paradise, Ca., a retirement community. Our patient population is approximately 60% Medicare, 15% Medi-cal and 25% private insurance. Past data releases have proven the average age of FRH Medicare patients to be older in most of the diagnostic categories, compared to other regional and statewide hospitals. FRH received no admission denials in this time period, reflecting high acuity of patients and appropriate usage of acute hospital level of care.

The information released presents mortality statistics specific to Feather River Hospital Medicare patients for the year 1986. The statistics represent the number of patients admitted within sixteen specific diagnostic categories, the actual percent of those patients who died within 30 days of their last admission of 1986, and a predicted range of the percent of patients who would have been expected to die, given adjustments for patient mix.

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System-West

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Joint Commission
on Accreditation
of Hospitals

The hospital specific data released for FRH has been reviewed by the Hospital Administrators, the Director of Medical Records/Quality Assurance and the Utilization Review Chairman and Coordinator. The information has been validated and is an accurate reflection of the statistics for this time period.

The medical staff of FRH conducts an ongoing intensive review of the medical record of every patient who expires at this facility regarding medical management and overall care. Therefore, it comes as no surprise to us that FRH statistics, in each of the sixteen diagnostic categories, falls within the "predicted range."

The four diagnostic categories that have the highest percentages are: cardiac, respiratory, cancer and cerebral vascular accidents (strokes). Attached you will find an article from the February, 1987 Paradise Post sighting the Butte County Health Official's assessment of causes of Butte County deaths in 1986. The top four categories in the county are: heart disease, respiratory disease, cancer and strokes.

In the remaining specific categories, FRH shows very low percentages.

To avoid the risk of breaching patient/physician confidentiality, FRH has requested an exclusion of four categories that contain only one or two deaths.

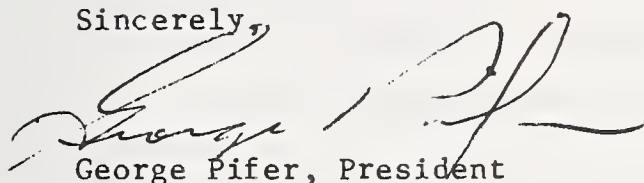
To quote William L. Roper, M.D., Administrator, Department of Health and Human Services, "... the information is not a total measure of quality of care at an individual hospital. While we believe that information on hospital mortality rates is useful, until we have developed additional statistical measures to deal with complex issues such as severity of illness, we cannot and do not recommend the use of the information by itself to make judgements about the quality of care in an individual hospital or to make comparisons among hospitals."

At FRH our ongoing monitoring systems for Quality Assurance, Peer Review and Utilization Review provide us with continuous feedback in an effort to continue to meet and exceed quality care standards.

Any questions about our section of the HCFA report or the above information may be directed to:

George Pifer
5974 Pentz Road
Paradise, Ca. 95969
Phone 916 877-9361

Sincerely,



George Pifer, President

Attachment

Cardiac disease foremost killer of county's residents last year

By Catherine Aaron
Post staff writer

County health officials vowed to battle smoking, traffic safety and to stress the importance of proper diet and activity after assessing the causes of Butte County deaths in 1986.

Heart disease continued to be the leading cause of death last year among Butte County residents, according to the county health department.

Cardiac problems were followed by respiratory diseases, cancers, strokes and other brain disorders, and accidents.

Nino Calarco of the department says there weren't many surprises in the year-end statistics round-up, which guides the department in setting its 1987 priorities.

Calarco said the results are "typical of the health situation we have in Butte County, but it helps us emphasize our efforts towards control."

Of the 1,789 deaths in the county, 805 were attributable to heart- and blood vessel-related conditions.

Lung problems, such as em-

physema, pneumonitis and influenza, caused 334 deaths countywide — a rate significantly higher than statistics in the state and nation, according to the health department.

Calarco says those lung problems are not attributable to causes in the county, since much of the affected population comes from other parts of the state.

"The population we have in Butte County acquired those problems as the result of industrial problems, smoking and contaminated air," says Calarco, "not causes produced by Butte County air."

Cancer deaths numbered 242, and accidents of all types claimed 80 lives. Sixty of those were a result of vehicular crashes.

Calarco calls the number of car-related deaths "unnecessary losses in lives and hundreds of needless injuries. It's about what you'd expect for a population our size, but that expectation is too high."

Suicides claimed 34 lives, kidney diseases resulted in 32 deaths, and stomach and intestinal diseases or complications took 23 lives.

A wide range of infections

resulted in 35 deaths, while 19 people died of liver complications including hepatitis.

Complications from long-term diseases resulting in malnutrition claimed 11 lives; Alzheimer's disease was the listed cause of death for one person.

There were seven homicides and six deaths associated with drugs or alcohol.

Diabetes claimed three lives and was a contributing cause to 84 other deaths.

AIDS was an underlying cause of four deaths, alcohol and drug problems preceded 17 deaths, and tuberculosis caused another two.

There were 10 infant deaths among babies under one year of age, four Sudden Infant Death Syndrome deaths and two newborn babies under one month of age were recorded as neo-natal deaths.

Thirty-nine deaths were attributed to a wide range of other diseases, or the specific cause is still under investigation.

While the number of deaths increased to an all-time high last year, health department staff says the increase is proportional to population growth.

**FHP Hospital — Fountain Valley**

OVERNIGHT COURIER

October 27, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

RE: COMMENTS ON MORTALITY RATE INFORMATION FOR FHP HOSPITAL (PROVIDER #050678)

The Health Care Financing Administration's data, as reported in the letter dated September 21, 1987 from William L. Roper, M.D., Administrator, HCFA, does not accurately report FHP Hospital's experience. This is attributed to lag time in the processing of claims thru the fiscal intermediary.

The hospital first opened in February 1986. Because FHP Hospital is a new facility, any data for the hospital is baseline data for future comparisons and activities. The Predicted Mortality Rates provided by HCFA were determined on the basis of an incomplete database. While FHP Hospital's actual mortality rates are within the predicted ranges, the HCFA predicted rates should not be considered meaningful under these circumstances.

The following figures for calendar year 1986 reflect deaths occurring only within FHP Hospital:

	<u>Diagnostic Category</u>	<u>Cases</u>	<u>Actual Mortality Rate</u>	<u>Range of Predicted Mortality Rate</u>
	All Causes	2005	5%	3 - 45%
CA	Cancer	205	11%	0 - 97%
CE	Stroke	90	13%	1 - 89%
GC	Gastrointestinal Catastrophies	47	9%	Not Available
GI	Gastrointestinal Disease	142	1%	0 - 97%
GU	Urological Disease	106	1%	0 - 100%
HM	Severe Chronic Heart Disease	114	5%	0 - 97%
HS	Severe Acute Heart Disease	69	7%	Not Available
ME	Metabolic & Electrolyte Disorders	40	10%	Not Available
OP	Orthopedic Conditions	76	5%	Not Available
PN	Pulmonary Disease	130	11%	0 - 97%
RN	Renal Disease	30	13%	Not Available
SE	Sepsis	19	21%	Not Available
TR	Trauma	127	4%	Not Available

9920 Talbert Avenue/P.O. Box 9920
Fountain Valley, California 92728-9920 (714) 962-HOSP



FHP Hospital — Fountain Valley

October 27, 1987

-2-

If there are any questions regarding this information, please contact

FHP Public Affairs
Stuart Byer, Associate Vice President
9900 Talbert Avenue
Fountain Valley, CA 92708

Sincerely,

A handwritten signature in dark ink, reading 'R. Lyle Luman'. The signature is written in a cursive, flowing style.

R. Lyle Luman
Associate Vice President - Hospitals

9920 Talbert Avenue/P.O. Box 9920
Fountain Valley, California 92728-9920 (714) 962-HOSP

CA 156.1

FOOTHILL PRESBYTERIAN HOSPITAL

Certified Mail
P 463 65 370

October 23, 1987

MEDICARE NUMBER #050597

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 16684
Baltimore, Maryland 21207

Dear Sir:

Thank you for the opportunity to respond to the Medicare Mortality data which you intend to publish later this year.

According to your statistics, the number of deaths of Foothill Presbyterian Hospital Medicare patients are within the range of predicted mortality rates. However, we felt it would be appropriate to respond regarding those categories which are in the upper limits of the statistical model. A special blue ribbon ad hoc committee of the Medical Staff was appointed to review all categories included in your letter of September 21, 1987, in which we were considered above mid-range.

CA - Cancer: By HCFAs count, there were 67 such cases assigned to our hospital. By our actual count, we had 101 separate cases of which there were 16 deaths, six of which occurred outside our hospital. This changes the percentage of deaths to 16% rather than the stated 24%, and places us at the extreme low end of the predicted range. We found no significant treatment problems in this disease category. In all cases, death was expected upon admission. Most were very old and classified as "no code" patients by the patients or their families.

CE - Cerebrovascular Accidents: Of the total charts reviewed, one history and physical, and one neurological workup could have had more detail. One had a weak discharge summary. However, it was felt the outcome would have been the same considering the advanced stage of the disease.

EY - Opthamologic Disease: No deaths occurred at our hospital.

GC - Gastrointestinal Catastrophes: Since the percentage of deaths attributed to this category was below the mid-range of predicted mortality rates, we did not review these cases.

GI - Gastrointestinal Disease: Well within the predicted range, therefore no cases were reviewed.

Health Care Financing Administration
October 22, 1987
Page Two

MEDICARE NUMBER #050597

GU - Urologic Disease: Well within the predicted range, therefore no cases were reviewed.

GY - Gynecologic Disease: No deaths occurred.

HL - Low Risk Heart Disease; HM - Severe Chronic Heart Disease; HS - Severe Acute Heart Disease: All of these categories were combined and reviewed by the same cardiologist. His comments are paraphrased as follows: The patients were all very old and their illness severity very high. In most cases the families had asked for no heroic measures. However, in order to assure a high level of care in the future, it was recommended that more specialist consultations be used on complex cases.

MS - Metabolic/Electrolyte Disturbances - We strongly suggest you eliminate this disclosure. Since only one death occurred, confidentiality could be breached.

OP - Orthopedic Disorders: Same as above. Since only one death occurred, confidentiality could be breached.

PN - Pulmonary Disease: On all cases reviewed, death was expected on admission. Patients were of a very advanced age with multiple medical problems. No codes/no heroics were generally ordered as requested by the family. Many came from local nursing homes.

RN - Renal Disease: Again, only one death in 11 patients. Disclosure of this data breaches confidentiality rules.

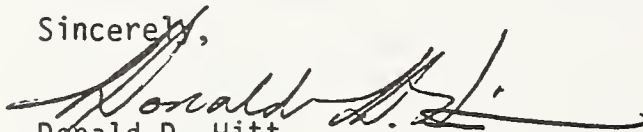
SE - Sepsis: Most of those patients included as mortalities were no code patients. Therefore, treatment was not aggressive. Regardless of the predicted outcome, it is being recommended that more aggressive use of antibiotics be considered on these types of patients in the future.

TR - Severe Trauma: No Medicare deaths were attributed to this diagnosis according to the HCFA data, and according to our records.

In conclusion, I want to assure you that this has been a very worthwhile effort at our hospital. As a result of this intensive review, we anticipate several worthwhile recommendations going to the Medical Staff. Those will improve documentation, the use of antibiotics and other peer review activities.

Again, thank you for the opportunity to respond prior to the publication of the Mortality Data.

Sincerely,


Donald D. Hitt
President

DDH:lmf



531 West College Street
Los Angeles, California 90012
(213) 624-8411

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

RE: French Hospital of Los Angeles Mortality Rate Information

Dear Dr. Roper:

French Hospital of Los Angeles is pleased to submit the following corrections and interpretive remarks to accompany the HCFA release of Mortality Rate Information later this year.

Data Verification

The data used by HCFA indicate that a total of 60 Medicare patients admitted to French Hospital died within 30 days of admission. According to HCFA data, 46 died while still a patient and 14 died after discharge. Our own records indicate that of the 1,255 total Medicare admissions occurring in 1986, 52 died within 30 days of admission to French Hospital.

If the HCFA records are accurate, 8 French Hospital patients listed as deceased within 30 days of admission were still alive at the time of discharge. (See attached corrections to data). It is impossible to determine whether the 8 patients who were discharged alive actually died within 30 days of admission to French Hospital as information concerning death after discharge is not included in the patient's medical record.

Interpretive Remarks

In all of the diagnostic categories used by HCFA, French Hospital's actual mortality rate falls within or is less than the range of the predicted mortality rate. Nonetheless, French Hospital questions the methodology used by HCFA to determine the predicted or acceptable range of mortality rates for each diagnostic category. The predicted results are limited by the variables taken into account. Further, holding a hospital responsible for the death of any patient after discharge may skew the actual mortality rates reported for that institution and grossly misrepresent the performance of the hospital.

Dr. William Roper
Page Two

Results of Preliminary Medicare Record Review

One cause of concern for French Hospital was the number of deaths reported as diagnosis "unknown." Upon review of these deaths we have determined that:

- . Five of the deaths could have been sufficiently categorized if the diagnostic categories used by HCFA were not so limited.
- . Two of the deaths were truly unusual cases wherein the principal diagnosis upon admission was unrelated to the cause of death. Further, the deaths occurred well after the date of discharge.
- . The final two deaths diagnosed "unknown" received limited workups due to the almost immediate demise of the patients after admission to the hospital.

Thank you for inclusion of these statements in the release of the mortality data. Please feel free to contact me with any questions or for further clarification.

Sincerely,



Donald W. Carrico
President
Chief Executive Officer

Enclosure: Corrected dates for admission, discharge and deaths



FRENCH HOSPITAL MEDICAL CENTER

1911 Johnson Avenue
San Luis Obispo, California 93401
(805) 543-5353

Medicare Provider Number- 050232

October 28, 1987

DATA VERIFICATION

The data used by HCFA indicate that a total of 79 Medicare patients admitted to French Hospital Medical Center died within 30 days of admission. Of these, 70 died while still a patient of the hospital, while 9 died after discharge. HCFA 's information states that French Hospital Medical Center had 792 Medicare admissions while our records indicate that 1153 Medicare admissions of individual beneficiaries to the hospital. Presumably the discrepancy reflects multiple admissions of the beneficiaries to our hospital. Our own records also indicate that of the 79 Medicare patients who died within 30 days of admission while an inpatient, 9 were still alive at the time of discharge. It is impossible to determine the percentage of the 9 patients dying after discharge actually died of the illness related to their hospitalization since that information is not accessible to the hospital.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in any analysis.

**FRENCH
HOSPITAL**



**MEDICAL
CENTER**

October 28, 1987

William Roper, M.D., Administrator
Department of Health and Human Services
Health Care Financing Administration
Washington, D.C. 20201

Re: 1986 Mortality Statistics

Dear Doctor Roper,

Thank you for the opportunity to respond to the release of data of hospital mortality rates for January 1, 1986 through December 31, 1986. Since receiving the report October 13, 1987 French Hospital Medical Center staff has had an opportunity to review the data.

The Director of Medical Records and our Quality Assurance Manager have screened the data and found that, with minor exceptions, the information is correct.

The French Hospital Medical Staff reviews all mortality cases for quality and appropriateness of care on an on-going basis. We believe that this system of continuous monitoring provides a feedback mechanism which enables us in our efforts to meet and exceed quality care standards. Trending analysis from these reviews is a constant endeavor to assist in identifying opportunities to improve care.

Again, thank you for the opportunity to review and clarify the mortality data.

Sincerely,

Beth O'Brien
Chief Executive Officer

Frederick K. Ostermann, M.D.
Chief of Staff



Community Hospitals of Central California

Fresno & "R" Streets, Fresno, CA 93721 / P.O. Box 1232, Fresno, CA 93715, (209) 442-3996
James D. Helzer - President and Chief Executive Officer

October 23, 1987

William L. Roper, M.D.
Department of Health & Human Services
Health Care Financing Administration
The Administrator
Washington, D.C. 20201

Dear Dr. Roper:

This letter is in response to your Administration's planned release of mortality data on the three acute hospitals which make up the Community Hospitals of Central California. Our three acute hospitals, Clovis Community Hospital, Sierra Community Hospital, and Fresno Community Hospital and Medical Center have reviewed this data and your analysis regarding the specific mortality data on Medicare patients who were treated between January and December, 1986.

In response to the data presented about our three hospitals, we would like to make the following general comments about your analysis.

1. All of our facilities indicate normal ranges of mortality rates in the vast majority of the diagnostic categories compared to other hospitals in the nation. We are proud of our overall status in relationship to all causes of death among our Medicare patients during the 1986 calendar year.

2. We have reviewed each of the documents for our facilities in detail and have found small inaccuracies which deal with some of the diagnostic listings and also the period of time in which it was administered. In the case of Sierra Community Hospital, only 10 months during the 12 month period were actually recorded in the data reported in your findings. Indications also show that at Sierra Community Hospital several of the cases are of individuals who are on the average 80 years of age with a variety of secondary diagnoses such as diabetes, chronic pulmonary disease, emphysema, and renal failure; these are contributing factors to the mortality statistics indicated in your records.



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Facilities: Clovis Community Hospital / Fresno Community Hospital & Medical Center / Sierra Community Hospital / Fresno Convalescent Hospital / Sierra Meadows Medical Service / Sierra View Convalescent Hospital
CA 166



William L. Roper, M.D.
Page Two
October 23, 1987

3. Fresno Community Hospital and Medical Center, which is a major tertiary care center for the Central San Joaquin Valley, sees a high number of elderly and acutely ill patients. This results in our statistical mortality being higher in certain categories because outlying facilities transfer acutely ill patients to us because of our complete range of health care services.

It should also be mentioned that all of our hospitals continue to operate Quality Assurance Programs that monitor all patient data in all areas of medical and surgical specialties. Our three individual medical staffs have reviewed for appropriateness all of the cases outlined in your data and we will continue to strive for the highest possible quality of care available in the area.

In closing, we would hope that in the future releases of this data you would provide us with the individual hospital identification numbers, length of stay for each patient, the average age by diagnosis category and if this data could also be reported in alphabetical order by discharge date. This information would make it easier for our staffs to analyze the data and review its accuracy.

Thank you for your attention to our comments and if any additional information can be provided by our organization, please do not hesitate to contact me at your convenience.

Sincerely,

Melvin J. Wexler, Vice President
Marketing Strategy

MJW:jl

Glendale Adventist Medical Center 1509 Wilson Terrace, Glendale, California 91206-4006 (818) 409-8000

October 27, 1987

William L. Roper, M.D., Administrator
Department of Health & Human Services
Health Care Financing Administration
Washington, D.C. 20201

**RE: 1987 HCFA Mortality Rate Report for Glendale Adventist Medical Center
(Provider #050239)**

Dear Dr. Roper:

Glendale Adventist Medical Center appreciates the opportunity to provide a written response in advance of the publication of the Mortality Rate Report by the Health Care Financing Administration.

We believe that while there may be some difficulties inherent in using mortality rates as a measure of quality in healthcare, the effort to provide the American public with reliable information on this important industry should not be discouraged. We welcome this effort to improve American healthcare.

This hospital takes the matter of quality in healthcare very seriously indeed. A series of internal quality-review mechanisms provides ongoing assessment of our healthcare delivery system, and helps to identify opportunities for improvement. For this reason the statistics provided in the present report hold no surprises for us.

Looking at the report in overall terms, it is worth noting that we are within the range of predicted mortality rates in all categories. The categories in which we are at the high end of the range will provide us with further areas of focus within our quality assessment programs, using our individual patient mix for comparison.

Again, we applaud HCFA's effort to provide evidence of quality in healthcare to the consumers. We trust the above information has served to further this effort.

Any questions about our section of the HCFA report, or the above information, may be directed to:

Name: Constance J. Thomas, Director of Quality Assessment
Address: 1509 Wilson Terrace, Glendale, Ca. 91206
Phone: (818) 409-8048

Sincerely,



David Nelson
Executive Vice President

DN:cmh



GLENDALE MEMORIAL HOSPITAL
AND HEALTH CENTER

1420 South Central Avenue
Glendale, California 91204-2594
(818) 502-1900

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

We respectfully request that the following information for Glendale Memorial Hospital and Health Center be attached to the Hospital Specific Report for Calendar Year 1986, prior to public disclosure.

Glendale Memorial Hospital and Health Center is a 310 bed, not-for-profit community hospital which has earned a reputation for excellence. Our acute care facility provides comprehensive medical and surgical services, including a complete range of cardiac services, orthopedic services, a cancer center, rehabilitation services, obstetric and gynecological services, a skilled nursing facility, emergency, outpatient and disease prevention services.

Our ongoing Quality Assurance program directs that the Medical Staff reviews and evaluates all patient care rendered. This is done systematically and continuously. Mortality review is just one element of our program. Our system thus provides us with a continuous feedback mechanism which helps us not only to meet but exceed quality health care standards.

The Joint Commission on the Accreditation of Healthcare Organizations has recently bestowed on our hospital a three-year accreditation without contingencies. This award was earned, in part, because of our Quality Assurance program. The distinction places our hospital in the top 9% of 1,100 hospitals recently surveyed nationwide by the Joint Commission.

Based on a comprehensive review of the hospital-specific data reported by HCFA, the hospital President, Chief of Staff, Chairman of the Quality Assurance Committee, Vice President of Nursing, Director of Medical Records, Director of Utilization Management and Director of Quality Assurance have validated that, with a few minor exceptions, the data is accurate. The actual mortality rate of 14% for all causes is well within the range of predicted mortality rates of 10% to 17%. Likewise, we were well within the range of predicted mortality rates for each of the diagnostic categories.

The Medical Staff of Glendale Memorial Hospital and Health Center will continue to review for quality and appropriateness all care rendered to our patients. The results from these reviews will provide opportunities for further improving care.

Thank you for the opportunity to offer this response.


Donald Begdon M.D.
Chief of Staff


William D. Parente
President



Goleta Valley Community Hospital

October 21, 1987

Hospital No. 050357

The following information for Goleta Valley Community Hospital is to be attached to the Hospital Specific Report for the calendar year 1986, which is a report of all medicare deaths that occurred within 30 days of admission to the hospital.

Goleta Valley Community Hospital is a 150-bed acute care facility whose case mix includes many patients with major medical illnesses. GVCH is a full-service hospital offering care in specialty areas of oncology, major orthopedic services, general medicine and surgery, as well as a referral center for cardiac surgery.

The Medical Staff, under the auspices of a hospital-wide quality assurance program, conducts an intensive review of the medical record of every patient who expires at the facility, regarding the overall medical management. Mortality review, as well as morbidity screens, are the ongoing process of the peer review function and an integral part of the monitoring of the health care delivery system at this hospital.

The hospital specific mortality data reported by HCFA has been carefully reviewed by the hospital Administrator, the Chief of Medical Staff, the Physician Chairman of the Quality Care Committee, and the Director of Medical Records, who has validated, with minor exception, that the data is accurate. Our position, being well within, and in some cases at the lower end of the predicted range, combined with a high case mix, confirms the quality of medicine practiced at Goleta Valley Community Hospital.

Sincerely,

David C. Bigelow, Administrator
Goleta Valley Community Hospital

A Non-Profit Community Hospital David C. Bigelow, Administrator BOARD OF TRUSTEES: Donald M. Anderson • Thomas C. Bazemore • David C. Bigelow • Edward E. Birch, Ph.D.
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351 South Patterson Avenue • Santa Barbara, California 93111 • (805) 967-3411

CA 173

MEDICAL
STAFF



THE
GOOD
SAMARITAN
HOSPITAL
OF SANTA CLARA VALLEY

2425 SAMARITAN DRIVE
SAN JOSE, CALIFORNIA 95124
(408) 559-2011

An Affiliate Of

HEALTH
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THE GOOD SAMARITAN HOSPITAL
OF SANTA CLARA VALLEY
SAN JOSE HEALTH CENTER/
SAN JOSE HOSPITAL
WHEELER HOSPITAL
SOUTH VALLEY
INTERCOMMUNITY HOSPITAL (1988)
HEALTH ADVANTAGE

October 27, 1987

William L. Roper, M.D.
Administrator
Department of Health
and Human Services
Washington, D.C. 20201

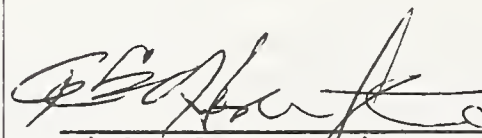
Dear Doctor Roper:

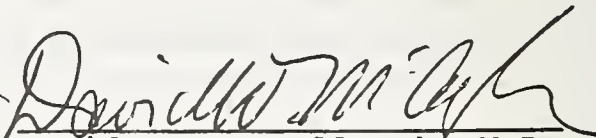
Thank you for the opportunity to respond to the HCFA mortality statistics for 1986. The improvement in your data system is noteworthy, but; as you point out, such hospital mortality rates do not address the complex issues of comparisons of the quality of health care.

We are most pleased to find that the Good Samaritan Hospital's actual mortality is in the lower half of the range in 13 of the 17 categories, and that we have 0% in 3 categories. Since we are proud of our reputation for acute cardiac care and surgery, and are referred many patients from other hospitals when they are acutely ill, we are especially pleased that our mortality for "Severe Acute Heart Disease" is in the lower range.

Each of our deaths as well as other events is routinely and carefully reviewed by peers on the medical staff, and the entire process is overseen by the Quality Assurance Committee, consisting of the key leadership of the hospital and medical staff. We have found that other indicators such as infection rates, and infant mortality rates are consistently below the average for community hospitals according to the Center for Disease Control and the State of California Department of Health. We are happy to have your information to further assist us in our Quality Assurance Program.

Sincerely yours,


Richard E. Herington
President


David W. Mc Cullough, M.D.
Chief of Staff and Chairman
Quality Assurance Committee

October 26, 1987

GRANADA HILLS COMMUNITY HOSPITAL

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Sirs,

After reviewing HCFA data listing mortality rates for Medicare patients treated in 1986 at Granada Hills Community Hospital, I would like to make the following observations. Although our mortality rates for most categories are well within the range of predicted mortality rates, certain unique medical programs provided at this facility may influence mortality rates for some categories.

<u>Cancer:</u>	Predicted Mortality Rate	-	13%-38%
	GHCH Actual Mortality Rate	-	37%

Granada Hills Community Hospital had initiated a Symptom Control Program for Terminally Ill to provide a comfortable setting for patients who were expected to die. Out of the 22 cancer deaths experienced in Medicare patients in 1986, 16 of these occurred in the Symptom Control Program. Each of the 22 patients who died of cancer had multiple diagnoses upon admission.

<u>Cerebrovascular Accidents:</u>	Predicted Mortality Rate	-	15%-45%
	GHCH Actual Mortality Rate	-	46%

Out of 35 Medicare cases admitted for cerebrovascular accidents (strokes) at Granada Hills Community Hospital in 1986, 16 deaths occurred. Out of these 16 incidents, 13 of these patients had a history of cerebrovascular accidents or a multiple of other medical diagnoses and all the remaining suffered massive strokes. Due to the severity of illness in this category, death was an expected outcome.

<u>Renal Disease:</u>	Predicted Mortality Rate	-	5%-56%
	GHCH Actual Mortality Rate	-	55%

Of the six deaths which occurred in this category, all experienced chronic and/or acute renal disease with multiple system diseases. Given the severity of illness, death was an anticipated outcome.

Health Care Financing Administration
October 26, 1987
Page 2

Granada Hills Community Hospital is committed to providing quality care. Quality assurance and mortality review programs are an integral part of the health care process at all hospitals such as ours that are accredited by the Joint Commission.

We welcome the opportunity to discuss the quality of care and services at Granada Hills Community Hospital. If you have any questions, please feel free to call the hospital at 818/360-1021, extension 6457.

Thank you for this opportunity.

Sincerely,

A handwritten signature in cursive script that reads "Dennis Coleman". The signature is written in dark ink and is positioned above the printed name and title.

Dennis E. Coleman
Chief Executive Officer

DEC:ss

CA 175.1

GROSSMONT HOSPITAL

A District Hospital
P.O. Box 158, La Mesa
California 92044-0300
(619) 465-0711

MEDICAL STAFF OFFICERS:

QUENTIN H. LEHMANN, M.D.
Chief of Staff

MAYNARD R. OLSEN, M.D.
Chief of Staff Elect

CHARLES H. WHITE, Ph.D.
Executive Assistant
to the Chief of Staff

October 26, 1987

Health Care Financing Administration
Health Standards and Quality Review
Hospitality Morality Information
P.O. Box 26684
Baltimore, Maryland 21207

Thank you for the opportunity to comment on hospital mortality statistics. Grossmont Hospital has been greatly assisted by the American Hospital Association paper on "Understanding Mortality Rates" and we will follow that format in responding to you.

We believe your methodology is still evolving and your model is only partially satisfactory. A particular weakness is still the attribution to a hospital of deaths that occur after the acute care episode. However, adding the pressure of comorbid conditions to the model is an improvement over prior data releases.

Grossmont has no need to be defensive for any reason. According to your data death rates are within predicted ranges. Perhaps, this is a better opportunity to comment than some other occasion when some other pattern is shown. It is still difficult to accept your basic assumption underlying the predictive model, that all patients, all hospitals and all treatment can be averaged without taking into account differences in types of patients admitted or differences in treatment.

We agree with AHA comments that the model does not consider all factors that significantly influence the risk of death in addition to the five characteristics chosen (age, sex, number of prior hospitalizations, transfer from another hospital, other complicating illnesses). While those characteristics may crudely predict risk of death for any individual patient, they do not predict hospital mortality rates. And, the model is still experimental and unproven.

Grossmont has reviewed HCFA data and find little error in number of cases, number of deaths, and deaths outside the hospital. But we have no way to verify deaths which occur after discharge from the hospital.

Attached is one of our worksheets showing those calculations. Grossmont does not show unusually large percentages of death after discharge, other than perhaps the "other causes" category which was not traceable because data was not presented.

Grossmont Hospital, as a 425 bed tertiary-care community hospital offers a broad range of specialized services. Medicare patients were 29% of discharges in fiscal year 1985-86, amounted to 40% of patient days and 47% of charges. Oncology treatment and pulmonary patients are attracted to Grossmont because of the reputation of the medical staff. As the major provider of care in Eastern San Diego County, Grossmont is classified as a disproportional provider of care to indigent and Medi-Cal patients. Whether HCFA data predicting mortality rates is an achievable target for the hospital is not clear from this release.

There is a noticeable shortage of long term beds in this area and 1985 data from the PRO (California Medical Review Inc.) shows that at least 10% of Grossmont admissions are transfers from nursing homes.

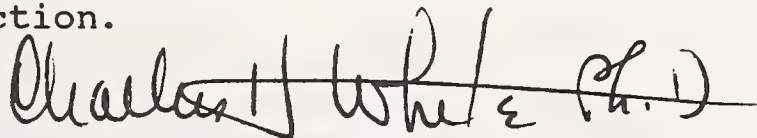
All deaths in the hospital are included in the peer review process as a generic criterion. No higher than expected mortality rates or patterns were detected.

Suggestions for improvement in future analyses that could produce more reliable and valid findings include:

- * using severity of illness measures
- * specifying cause of death
- * comparing cause of death for reason of admission
- * adding patients that died in hospital later than 30 days
- * adding patient general health status, stage of illness, psychological condition and family support.

Without such refinements, the HCFA prediction internal model will not measure hospital performance.

In summary, we accept our responsibility to evaluate our medical care and we have working mechanisms in place to accomplish that purpose. We are grateful for the opportunity to respond and we have attempted to present a positive and useful effort in that direction.

A handwritten signature in dark ink, appearing to read "Charles H. White, Ph.D.", with a horizontal line drawn through the middle of the signature.

Charles H. White, Ph.D.
Executive Assistant to the Chief of Staff

CWH/tf

Enclosure

cc: Michael Erne, CEO
Quentin Lehmann, M.D., Chief of Staff
Board of Directors
Carol M. McCarthy, Ph.D., President, AHA
Daniel P. Bourque, Voluntary Hospitals of America

Analysis of HCFA Mortality Report September 21, 1987

Category	Risk	Admissions	Deaths	Rate	Predicted%	# After Discharge	% After Discharge	# Expired In Hospital	% Expired In Hospital
Cancer	H	344	113	33%	18 - 33	16	14%	97	86%
CVA	H	142	45	32%	21 - 37	8	18%	37	82%
Ophthalmologic d.	L	6	0	0	0 - 100	0	0	0	0
GI catastrophies	H	80	15	19%	9 - 29	2	13%	13	87%
GI d.	L	317	25	8%	3 - 10	6	24%	19	76%
Urologic d.	L	158	4	3%	2 - 11	2	50%	2	50%
Gynecology d.	L	40	1	3%	0 - 30	0	0	1	100%
Low risk heart d.	L	330	21	6%	3 - 8	7	33%	14	67%
Severe chronic heart d.	H	197	44	22%	17 - 31	13	30%	31	70%
Severe acute heart d.	H	148	60	41%	31 - 49	6	10%	54	90%
Metab/elect. disturbance	H	118	30	25%	10 - 29	12	40%	18	60%
Orthopaedic disorders	L	241	10	4%	0 - 5	2	20%	8	80%
Pulmonary d.	H	397	103	26%	15 - 26	16	16%	87	84%
Renal d.	H	34	5	15%	8 - 43	0	0	5	100%
Sepsis	H	49	21	43%	22 - 52	7	33%	14	67%
Severe trauma	H	117	9	8%	5 - 17	2	22%	7	78%
Other dx categories		1,183	45	4%		19	42%	26	58%
TOTAL:		3,901	551	14%		118		433	

30% of all admissions were in "other diagnostic categories."
 3% of all cases died after discharge
 21% of all deaths died after discharge

ml10/7/87 [HCFA]



HANFORD COMMUNITY HOSPITAL

450 Greenfield Avenue P.O. Box 240 Hanford, California 93232 (209) 582-9000

October 27, 1987

William L. Roper, M.D.
Department of Health & Human Services
Health Care Financing Administration
Washington, D.C. 20201

RE: 1987 HCFA Mortality Rate Report for Hanford
Community Hospital
Provider # 050121

Dear Dr. Roper:

Hanford Community Hospital appreciates the opportunity to provide a written response in advance of the publication of the Mortality Rate Report by the Health Care Financing Administration. Although it is generally accepted that mortality data does not necessarily reflect the quality of care provided to patients, the effort to provide the American public with reliable information on this important industry should not be discouraged. We welcome this effort to improve American health care.

Our hospital is very concerned about quality in health care. A series of internal quality-review programs provides ongoing assessment of how we are doing and helps to identify ways we can do even better. All deaths occurring in the hospital are reviewed by a medical staff committee on a monthly basis. For this reason, the statistics provided in the present report hold no surprises for us.

Although all the actual mortality rates for Hanford Community Hospital were within the range of predicted mortality rates specific for our hospital, we believe there is additional information that should be taken into account in evaluating several areas.

Severe Chronic Heart Disease

Within this diagnostic category there were 12 deaths out of 41 cases or a 29% mortality rate. The average

William L. Roper
October 27, 1987
Page 2

age of these patients was 77. Three of these cases had multiple complications and were severe enough that the patient, family and physician had agreed not to make any effort to resuscitate the patient due to the poor prognosis. Six others expired in the hospital due to cardiac arrest. These patients had a long-term history of serious cardiac problems. One of the other cases died 12 days after discharge in a convalescent facility due to cardiac arrest due to chronic obstructive pulmonary disease and heart failure. One other case died in the hospital due to a massive stroke.

Renal Disease

Six deaths were reported out of 12 cases. Four of these deaths were individuals who had irreversible severity, and documentation was made by patient's family and physician that efforts should not be made to resuscitate the patient due to a poor prognosis. One of the other cases in this category died five days after discharge at home from heart failure and chronic obstructive pulmonary disease. The last individual was discharged to a convalescent facility with acute renal failure and died 15 days later. The average age of the patients who expired in this category was 79.

Again, we applaud HCFA's effort to provide evidence of quality in health care to the consumer. We trust the above information has served to further this effort. Any questions about our section of the HCFA report or the information may be directed to Lynda Longhofer, Marketing Department, (209) 582-9000, Ext. 3121.

Sincerely yours,



Charles S. Ricks
President



Lyman Rust, M.D.
Chief of Medical Staff

rm



October 26, 1987

Medicare Provider # - 05-06-07

William L. Roper, M.D., Administrator
Health Care Financing Administration
6325 Security Boulevard
Baltimore, MD 21207

Dear Dr. Roper:

In response to the mortality data released to our Hospital in your September 21, 1987, correspondence, it should be noted that on an ongoing basis the Medical Staff has always reviewed every mortality case in our facility for appropriateness of care as a part of the Hospital's Quality Assurance program. We are committed to provide only the highest standard of care to our patients, which entails careful review of all services delivered through our institution.

CORRECTIONS:

- According to our hospital data there were 483 Medicare discharges for the year 1986 instead of the 430 as reported in your data.
- There are two cases listed with incorrect date of discharge/death.
 - o The second case, [REDACTED] should have a discharge date of [REDACTED], the same as date of death.
 - o The thirteenth case, [REDACTED], date of death should be [REDACTED] the same as date of discharge, instead of [REDACTED]

COMMENTS:

- Of the inhouse deaths, thirteen of these cases were transfers from facilities that provide a lower level of care, after the clients became critically ill.
- Of the inhouse deaths, twelve of the cases were expected deaths because of the nature of their illnesses.

Harbor View Medical Center
October 26, 1987
Page Two

- Of all cases reported, with the exception of two, deaths were of an age greater than seventy years, the average age of death being eighty-five years.

QUESTION:

- The report shows a death that occurred in 1987 after a 1986 hospitalization. This death occurred inhouse in 1987. Will the same death be included as part of mortality data released for 1987?

The Medical Staff of Harbor View Medical Center, as has been their practice, shall continue to review all mortality cases for quality and appropriateness of care rendered to the individual patient. Trending analysis from these reviews is a constant endeavor to assist in identifying opportunities to improve care.

Thank you for the opportunity to express our comments and have them included as a part of the information that shall be released with the mortality data regarding our Hospital.

Sincerely,

Margareta Norton
Executive Director

MN/jt



THE
HAYWARD HOSPITAL
INTERDEPARTMENT CORRESPONDENCE

COMMENTS ON THE HCFA MORTALITY DATA
THE HAYWARD HOSPITAL
HAYWARD, CALIFORNIA

Medicare Provider # 05-0395

Thank you for the opportunity to provide input regarding the mortality statistics for the period January 1, 1986 through December 31, 1986.

The Hayward Hospital is a 166-bed general acute care hospital serving the community of Hayward. We provide a wide range of medical services including inpatient and outpatient surgery intensive care unit, cardiac care unit, emergency room, radiology, laboratory, pharmacy, podiatry clinic and residency program, and adult and adolescent substance abuse programs. The Hospital treats a high percentage of Medicare and Medi-Cal patients.

Since receiving the mortality statistics on September 29, 1987 the data has been analyzed by the Chief of Staff, the Administrator, Chairman of The Quality Assurance Committee, Chairman of the Utilization Review Committee, the Director of Nurses, Director of Medical Records, the Quality Assurance Coordinator and the Utilization Review Coordinator.

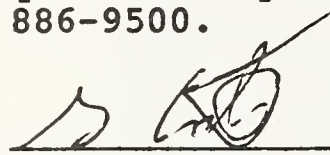
We uncovered several minor errors in the data. With the corrections made our "All Causes" mortality rate dropped to 11%, our "Severe Chronic Heart Disease" rate dropped to 28% and our "Metabolic/Electrolyte Disturbances" rate dropped to 6%. Even without the corrections we were very pleased to see that all of our mortality rates fell within the predicted range. We can say with 95% confidence that the actual mortality experience at The Hayward Hospital is at the expected level for a hospital with our services and type of patients.

The Medical Staff at The Hayward Hospital conducts an intensive review of the medical record of every patient who expires at this facility. This review explores both medical management and overall quality of care and is an ongoing part of the Quality Assurance

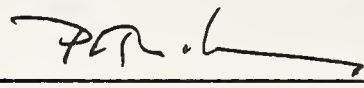
Committee and peer review activities. We believe that our review process and educational feedback to physicians provides a continuous mechanism that allows us to not just measure quality, but to ensure quality.

Although this mortality data provides limited information that is likely to be mistakenly used as a measure of quality of care, we applaud these initial steps at providing information to the consumer that will help them to become more active and informed in their health care decisions. We hope that future data will be of a more direct benefit to the consumer.

If the mortality information or these comments generate any questions, please contact Phil Herschman, Administrator at (415) 886-9500.



Gerald Coats, M.D.
Chief of Staff
10/87/ap



Philip L. Herschman
Administrator

HEMET VALLEY HOSPITAL DISTRICT

THOMAS J. BRODERICK, M.B.A.
Administrator

Fully Accredited by
Joint Commission on
Accreditation of Hospitals

Member of
American Hospital Association
California Hospital Association
Association of Western Hospitals
Association of California
Hospital Districts
Hospital Council of Southern
California



1117 East Devonshire Avenue
HEMET, CALIFORNIA 92343
Telephone 652-2811
Area Code 714

EARL L. ALDERSON, Ph.G.
President

PAULINE S. HILLIS
Vice President

PATRICIA T. TULLER, R.N.
Secretary

ROBERT A. SMITH, M.D.
Director

ROBERT J. McNERNEY, M.A.
Director

October 26, 1987

RE: Hemet Valley Hospital
Mortality Statistics
October 1, 1984 - September 30, 1986

Thank you for this opportunity to respond to the release of data on hospital mortality rates for October 1, 1984 through September 30, 1986. Since receiving the report, September 23, 1987, a special hospital/medical staff task force has reviewed these data.

The Managers of Medical Records and Utilization Review have sampled our records pertinent to your data and have verified that, with some exceptions, your data are correct. On an ongoing basis the appropriate clinical department of our hospital reviews every mortality. We had already done this for every accurate patient in your report, with the exception of a very small number who died in a skilled nursing facility or elsewhere following discharge.

Based on the comprehensive review of the data and the specific medical records it reflects, we are confident that you and any member of the public who requests a copy of our statistical information will be interested in our summary report.

Our Administrative and Medical Staff take pride in the overall lower than expected mortality rates. Since our hospital primarily serves a number of retirement communities, our patients tend to be extremely elderly with multisystem diseases and may have a higher than expected mortality rate. We compliment you, therefore, on making statistical adjustments for the data you released regarding our population.

Although in most categories our actual mortality rate was either within the expected range or lower, we find that we exceeded the expected rate where cerebrovascular accidents are concerned. The physicians and personnel of the task force, therefore, reviewed patient records in this category with particular attention.

Few patterns were evident, other than those in keeping with the extreme age of the population, co-morbidity, and interaction with the numerous skilled nursing facilities in our area. Of the 60 total deaths in this category, 45 came into the hospital with "No Code" instructions. All were admitted with CVA. Five entered from skilled nursing facilities; nine were discharged to skilled nursing facilities. A very high co-morbidity rate was evident.

We also reviewed charts in another category; severe acute heart disease. Although our rates were within the expected range, they were at the high end. Here we found coding errors on 3 patients. They should not have been in this category. Also, one patient you listed was never a patient of ours. This lowers the rate to within the expected range. Nearly one third were admitted either with a ruptured aortic aneurysm or in full arrest, conditions with very high mortality risk. Thirty-four of these patients also were "No Code."

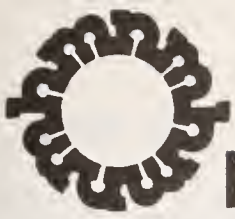
Our Medical Staff is in process of reviewing these findings of the task force, with a focus on the two above mentioned categories.

Again, thank you for the opportunity to present this response. If you or anyone receiving this information has additional questions, please do not hesitate to call.

Sincerely,



Neva M. Olson
Assistant Administrator



... Committed to your good health

Henry Mayo Newhall Memorial Hospital

23845 West McBean Parkway Valencia California 91355 Telephone (805) 253-8000

October 23, 1987

William L. Roper, MD
Administrator
Health Care Financing Administration
PO Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Attached are the comments from Henry Mayo Newhall Memorial Hospital which should be distributed to parties that request reports of HMNMH data on Medicare patients.

Thank you for the opportunity to submit these comments.

Yours very truly,


Duffy-Watson
President

db1143

A COMPREHENSIVE, NON-PROFIT HEALTH CARE CENTER - OWNED AND OPERATED BY THE SANTA CLARITA HEALTH CARE ASSOCIATION

BOARD OF DIRECTORS: Howard P. Buck, M.D., Chairman; Rev. Robert Brigham, Vice-Chairman; Judge Roger W. Borer, Secretary; W. Bruce Gephart, Treasurer; Ben W. Burke, Ben W. Cyrus, Rita Garas, Howard L. H., Gary D. London, M.D., Anthony C. Matress, Peter E. Parker, M.D., E. Swann P. P., M.D., William P. Rattazzi, William A. Schmidt, Duffy Watson.



... Committed to your good health

Henry Mayo Newhall Memorial Hospital

23845 West McBean Parkway Valencia California 91355 Telephone (805) 253-8000

Provider # 050624

Henry Mayo Newhall Memorial Hospital (HMNMH) is a 133-bed non-profit community hospital located in the Santa Clarita Valley. The population served by the hospital includes young families as well as people 65 years and older, eligible for Medicare. 26% of the adult admissions to the hospital are Medicare patients.

According to the information from the Health Care Financing Administration (HCFA), the 11% mortality rate for HMNMH's 1986 Medicare patients is well within the 8 to 15% range of predicted mortality rates for our hospital.

HMNMH's actual mortality rates for all the diagnostic categories specified by HCFA were also within the range of predicted mortality rates for each category, with the exception of Pulmonary Disease in which our mortality rate of 8% was actually lower than the predicted range of 11 to 31%.

Approximately 20% of the patients listed in the HCFA report died after leaving our hospital. Generally, these patients had multiple long term problems such as cancer and heart disease, and many returned to skilled nursing facilities after discharge from HMNMH.

The Medical Staff Death and Complications Committee reviews every death in the facility on an ongoing basis. This ongoing review provides us with a feedback mechanism which allows for continued provision of high quality care. This Committee will continue to review every death and the data produced by HCFA.

HMNMH has taken the following steps based on the review of data for 1986 by the hospital administrators, Chief of the Medical Staff, the Quality Assurance, Utilization Management, and Death and Complications Committees of the Medical Staff, the Director of Patient and Quality Assurance Services Department, and the Director of Medical Records:

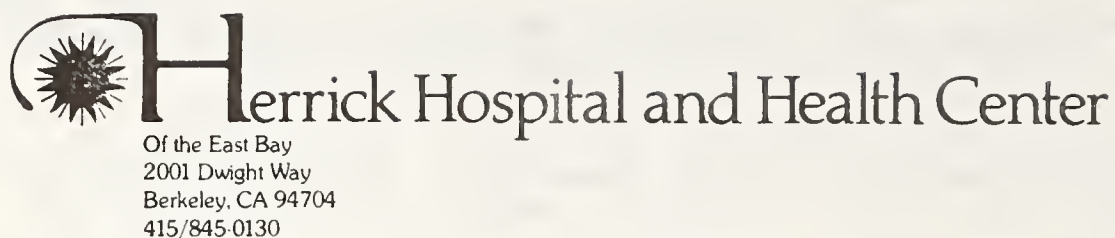
- *All deaths occurring after discharge from HMNMH were specifically reviewed by the Death and Complications Committee.
- *Significant findings of the HCFA data and evaluation by the medical staff committees have been distributed to the members of the medical staff.
- *The physicians, nurses, and representatives of hospital administration, working with all the medical and hospital committees, will continue to focus on ways to provide high quality care in an efficient manner.

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BOARD OF DIRECTORS: Howard P. Buck, M.D., Chairman; Rev. Robert Bingham, Vice-Chairman; Judge Roger W. Evers, Secretary; W. Brian George, Treasurer; Betty Burke, Ben W. Curtis, Rita Garas, Howard L. Hill, Gary D. London, M.D., Anthony C. Matthes, Peter E. Parne, M.D., E. Scott R. Pyle, M.D., William R. Rafferty, William A. Schmidt, Duffy Watson.

The HCFA data has confirmed the excellence of care provided at HMNMH, as the overall mortality rate of 11% for Medicare patients at the hospital is well within the predicted range of 8 to 15%.

Being a community-oriented facility, our aim is to continue to deliver the highest standard of care possible. We appreciate our community's support and always welcome comments and requests for further information.

db1122
1087



October 22, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, DC 20201

Dear Dr. Roper:

Provider Number: 050087

On behalf of the Board of Trustees, the administration and the medical staff of Herrick Hospital and Health Center, thank you for the opportunity to provide a response to the mortality statistics for calendar year 1986 compiled by the Department of Health and Human Services. We are pleased that the data indicate that the mortality rates experienced at Herrick fall within the predicted range in each of the diagnostic categories.

Herrick is a 248-bed acute care facility, which provides comprehensive care in the areas of rehabilitation, mental health, and older adult services. Herrick is the designated Emergency Department for the entire Berkeley-Albany area. In March of 1987, the hospital and medical staff started a renal transplant program. So far, 12 transplants have been performed with a 100% success rate.

The hospital's medical staff and administration closely monitor the quality of patient care through several mechanisms, but primarily through an ongoing Quality Assurance Program, which, as one of its responsibilities, reviews all deaths to assess medical management and overall care. Individual clinical departments of the medical staff are also responsible for monitoring and evaluating patient care provided in each of their departments. In addition, the medical staff conducts regular peer review activities.

The mortality data was reviewed by the physician chairman of the Utilization Review Committee, the executive director of utilization and case management, and the directors of medical records, quality assurance, and patient care management services. As we mentioned earlier, the data show that the mortality rates experienced at Herrick fall within the predicted range calculated by the Department for this institution in each of the diagnostic categories.

We support the efforts of the Department to inform the public concerning health care delivery, and we believe that the release of this report is a step in that direction. We understand that there are limitations on using this data and determining the overall quality of care at a facility solely by this report would be inappropriate. We look forward to further enhancements which will help the public better understand the complexities of measuring quality and, in turn, help them become better consumers of health care.

Dr. William L. Roper
October 22, 1987
Page 2

The Board, administration, and medical staff of Herrick will support this effort as well as continue to regularly monitor patient care to ensure quality care is provided to all patients at Herrick.

If there are any questions, please direct them to the Public Affairs Department, (415) 428-4545.

Sincerely,

Eleanor G. Claus

Eleanor G. Claus
Executive Vice President

Robert B. Doud

Robert B. Doud, M.D.
President, Medical Staff



HI-DESERT MEDICAL CENTER

October 22, 1987

RE: Health Care Financing Administration (HCFA) Mortality Statistics
January 1 through December 31, 1986

To Whom It May Concern:

Thank you for this opportunity to respond to the HCFA Mortality Data Release.

Since receiving the report in September, we at Hi-Desert Medical Center (HDMC), have had an opportunity to review the data:

The Medical Records Department has validated that with minor exceptions, HCFA's data is an accurate reflection of statistics at our facility.

Based on our comprehensive review of HCFA's data and the specific Medical Records which it reflects, you and any member of the public who request a copy of our statistical information will be interested in the following findings:

Hi-Desert Medical Center is a 56 bed Acute Care District Hospital. The hospital features a medical and surgical intensive care unit; comprehensive surgical facilities, including outpatient surgery; complete physical therapy and cardio-pulmonary departments; radiological and nuclear medicine services and a modern full service laboratory.

Approximately 72% of our total admissions are Medicare patients. Additionally, the following points also factor in our mortality rates:

1. Our desert community is primarily comprised of retired persons, many whom have come to the area for health related reasons.
2. A lower cost of living in the Morongo Basin results in an influx of less affluent elderly, who often do not adequately care for themselves or seek timely medical treatment.
3. There are two extended care facilities ECF's and three 'Board & Care' homes in the area (approximately 358 bed capacity) which consistently operate at a 95% + occupancy.

In reviewing the statistics, it is noted that Hi-Desert Medical Center's actual mortality rate is not significantly out of the range of the predicted mortality rate for our hospital in any of the 16 diagnostic categories.

6601 WHITE FEATHER ROAD / JOSHUA TREE, CA 92252 619 / 366-3711

Hi-Desert Memorial Hospital District

HDMC has an excellent quality assurance, risk management, and utilization review program. On an on-going basis, the quality assurance coordinator reviews all death charts, using criteria approved by the medical staff. If a chart fails to meet this criteria, the chart is then reviewed by a quality assurance physician, and appropriate action is taken if necessary. On a concurrent basis, the utilization review department reviews every chart within 24 working hours of admission and on a daily basis thereafter, using nationally recognized quality criteria, to insure that the admission was necessary and that treatment is appropriate and timely. When a chart does not meet this criteria, it is promptly referred to a quality assurance physician for further review and appropriate action. This information is then appropriately shared with the quality assurance committee (comprised of physicians, administration, and nurses) on a monthly basis to assure the quality of individual care.

Again, thank you for the opportunity to present this response. If you or anyone receiving this material have additional questions, please do not hesitate to call.

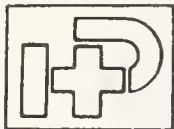
Sincerely,



Dr. Jerome Seeraty
Chief of Staff



Dr. Stephen Bush
Quality Assurance Chairman



Hollywood Presbyterian Medical Center

Allene Nungesser
Chief Executive Officer

1300 North Vermont Avenue
Los Angeles, California 90027
(213) 660-3530

October 21, 1987

To Those Concerned:

Please accept the following response on behalf of Hollywood Presbyterian Medical Center to the mortality statistics released by the Health Care Financing Administration (HCFA) for the period of January 1, 1986 through December 31, 1986. Hollywood Presbyterian Medical Center falls well within the range of the overall mortality statistics presented for the entire United States.

Of the seventeen sub-categories presented, HCFA indicated that Hollywood Presbyterian Medical Center ranked within the predicted mortality range in fifteen of the seventeen. However, after careful review of each case involved in both sub-categories where Hollywood Presbyterian Medical Center had higher percentages, it has been found that clerical errors in compiling the principal diagnosis data resulted in an overstated percentage of mortality in the diagnosis category of Severe Acute Heart Disease. After adjusting for these discrepancies, Hollywood Presbyterian falls within the compliance parameters in 16 of the 17 categories.

Cerebral Vascular Accidents (strokes) is the only category where our mortality statistics are slightly higher than the predicted rates. In reviewing these cases, the following facts are noted:

- 61.7% (21 out of 34) came through the Emergency Room and were admitted directly into a critical care unit, which indicates that these patients were in severe distress at the time of admission.

- 52.9% of the cases (18 out of 34) were over 80 years of age.

- 55.8% of the cases (19 out of 34) were comatose upon admission; and of these, 5 (26.3%) had requests made by the family to use no emergency resuscitation measures.

- 61.7% of the cases (21 out of 34) had significant comorbidity (other illnesses contributing to the overall severity of the patient's condition).

October 21, 1987

Page two

Mortality review is an ongoing process of Hollywood Presbyterian Medical Center's Quality Assurance program. Medical peer review activities and review of medical management and overall care are integral parts of the hospital's quality monitoring system, and we are confident as a result of these reviews that the care rendered at Hollywood Presbyterian Medical Center continues to be appropriate and consistent with community standards.

Thank you for the opportunity to present this response. If you, or anyone receiving this information, has additional questions, please contact Sandi Chester, Vice President, Planning and Quality Management at (213) 660-3530, extension 6900.

Sincerely,

A handwritten signature in cursive script that reads "Allene Nungesser".

Allene Nungesser
Chief Executive Officer

AN:mh



THE HOSPITAL OF THE GOOD SAMARITAN
AN AFFILIATED HOSPITAL OF THE UNIVERSITY OF SOUTHERN CALIFORNIA
616 South Witmer Street, Los Angeles, California 90017-2395 • (213) 977-2121

WRITER'S DIRECT DIAL NUMBER

CONTACT: Gail Sidney
(213) 977-2094

October 22, 1987

TO: All Interested Parties

SUBJECT: 1986 Health Care Finance Administration Mortality
Rate Statistical Release for Medicare Patients

The Hospital of the Good Samaritan in downtown Los Angeles appreciates the opportunity to comment on the HCFA hospital-specific data released to the public and submits the following to assist you in interpreting the statistics.

The Hospital of the Good Samaritan is a 411-bed acute care facility with centers of excellence in Cardiology and Cardiovascular Surgery, Cancer, Neuromuscular Diseases, Nursing and Outpatient Services.

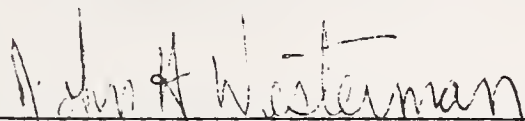
While offering state of the art technology and care, we continue to explore new alternatives for delivering an exemplary level of diversified clinical services, and serve as a tertiary referral service for cardiac care. A longstanding affiliate of the University of Southern California School of Medicine, the hospital is committed to the educational process and to broadening our medical knowledge base in order to provide the highest quality level of patient care.

The Hospital supports the public's desire for information which is both accurate and pertinent to their healthcare decisions. Still, the process of compiling and analyzing the information is in evolution and we find some discrepancies between the HCFA data and our own statistics. It is also important to remember this data is not adjusted to allow for individual patient severity of illness differences nor does it take into account those patients who underwent surgery versus those who did not. We suggest the public view this data with these points in mind and avoid drawing conclusions about quality of care for any hospital on the basis of statistics alone.

The medical record of every patient who expires at The Hospital of the Good Samaritan is thoroughly reviewed by the Medical Staff as part of our extensive quality assurance program. Peer review and monitoring of the healthcare delivered at Good Samaritan is an ongoing process supported by both hospital administration and the Medical Staff.

The Hospital of the Good Samaritan is committed to providing the highest quality of patient care in an effective and dignified manner. Again, we appreciate the opportunity to provide comment on these statistics.

Sincerely,



John H. Westerman
President and Chief Executive Officer
The Hospital of the Good Samaritan



David S. Cannon, M.D.
Chairman
Quality Assurance Committee



William H. Kern, M.D.
Chairman
Medical Staff

Humana Hospital
West Anaheim

October 22, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

RE: RESPONSE TO HCFA ON HOSPITAL MORTALITY RATES

Gentlemen:

Thank you for the opportunity to comment on the hospital's specific mortality data provided to us late last month. Humana Hospital-West Anaheim supports the Health Care Financing Administration's desire to educate those interested in Medicare quality issues. We recognize this program is early in its development stages. While its measurements are preliminary and rough, it is clearly an example of the type of quality measurements to come.

This information is helpful in our hospital's ongoing quality assurance program that includes regular and complete review of all admissions which result in patient mortality, regular morbidity and mortality reviews, quality assurance, utilization review, as well as complete outside review by the Joint Commission on Accreditation of Health Organizations and other outside review organizations.

Since these raw numbers reflect deaths which occurred in only a limited segment of a hospital's patient population (the elderly) and are not adjusted for severity of illness or other factors which may affect patient outcome, they must be considered in that context and should serve only as one of numerous indicators used to review the quality of services provided at an individual hospital. While this statistical data is useful in this format for professional evaluation, it is not beneficial for consumer use. As a result, consumers should be informed as to the limited scope of these numbers and be cautioned about drawing any conclusions from the data about the quality of a particular hospital's services.

As in all deaths occurring in hospitals, a complete internal review is necessary to determine the appropriateness of the outcome and may provide information to physicians and other medical providers about

improvements which can be made in treating future patients. Thus, the use of raw mortality statistics is helpful to professionals in identifying patient trends and treatment outcomes. Additionally, they may assist health care consumers in understanding the extensive quality control systems in place in hospitals.

Our hospital (medical records, quality assurance and medical staff) has reviewed the data. Since nineteen deaths occurred outside the hospital, we have been unable to completely validate this data. While we have found some consistency with the HCFA data, we have also identified some major areas of unverifiable data (e.g. HCFA reports deaths of two patients without record of admission to the hospital). Unfortunately, in some cases, the number of patients in a particular category is too small to provide a valid statistical analysis. In addition, the predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner, it would be inappropriate to consider them acceptable or unacceptable "standards".

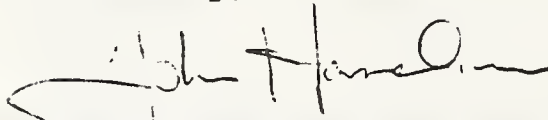
Specifically, we reviewed all categories and find that significant notable characteristics were present in two categories. These categories are severe chronic heart disease and severe acute heart disease. The single most significant factor in the mortality rates of these two categories relates to the hospital's geographic location and affiliation with senior health care centers. Within a three mile radius of the hospital, there are eight skilled nursing facilities, six board and care centers, multiple mobile home parks, and a high percentage of senior home owners. As a result of the hospital's proximity and relationship to these centers, the hospital receives a disproportionate share of terminally ill patients.

Examples of the above mentioned factors can be demonstrated by the common characteristics throughout two disease categories. In the severe acute heart disease category, the average age of the patient was seventy-six years old. Twenty-six percent of patients were admitted from a nursing home, seventeen percent of which a joint decision between the family and the physician had been made to not resuscitate, and eight percent died within eight hours of their admission. Of the remainder in this category, seventeen percent were ill at home and an order to not resuscitate was present on the day of admission; eight percent had multiple chronic conditions and died from cardiac arrest; thirteen percent were found to be terminal by medical staff committee review; and twenty-one percent were hospitalized less than twenty-four hours. In all instances, physician review determined that care was in accordance with accepted community standards and the outcome was as expected.

The average age of the twenty-one patients with severe chronic heart disease was seventy-eight and one-half years. Sixty-six percent of the patients expired from congestive heart failure, a condition that normally results from long term noneffective pumping of the heart which ends in lung congestion. The same general characteristics as stated above exist in this patient population, i.e., nursing home admissions, short stays in the hospital, and orders to not resuscitate. All of these patients had multiple irreversible and chronic system problems. Each of these deaths was evaluated by several committees of physicians and all were found to have been managed appropriately.

We hope this information will be helpful in attempting to refine the collection and reporting of raw hospital data. In addition, our hospital will do everything possible to assist our community in understanding how this data can best be used to improve health care services.

Sincerely,

A handwritten signature in dark ink, appearing to read "John Hanshaw", with a stylized flourish extending from the end of the name.

John Hanshaw
Executive Director

Humana Hospital **Huntington Beach**

Medicare Provider #050526

RESPONSE TO HCFA ON HOSPITAL MORTALITY RATES

Thank you for the opportunity to comment on the hospital specific mortality data provided to us late last month. Humana Hospital-Huntington Beach supports the Health Care Financing Administration's desire to educate those interested in Medicare quality issues. We recognize this program is early in its development stages. While its measurements are preliminary and rough, it is clearly an example of the type of quality measurements to come.

This information is helpful in our hospital's ongoing quality assurance program that includes regular and complete review of all admissions which result in patient mortality, regular morbidity and mortality reviews, quality assurance, utilization review, as well as complete outside review by the Joint Commission on Accreditation of Health Organizations and other outside review organizations.

Since these raw numbers reflect deaths which occurred in only a limited segment of a hospital's patient population (the elderly) and are not adjusted for severity of illness or other factors which may affect patient outcome, they must be considered in that context and should serve as only one of numerous indicators used to review the quality of services provided at an individual hospital. While this statistical data is useful in this format for professional evaluation, it is not beneficial for consumer use. As a result, consumers should be informed as to the limited scope of these numbers, and be cautioned about drawing any conclusions from the data about the quality of a particular hospital's services.

As in all deaths occurring in hospitals, a complete internal review is necessary to determine the appropriateness of the outcome and may provide information to physicians and other medical providers about improvements which can be made in treating future patients. Thus, the use of raw mortality statistics is helpful to professionals in identifying patient trends and treatment outcomes. Additionally, they may assist health care consumers in understanding the extensive quality control systems in place in hospitals.

Humana Hospital-Huntington Beach is a 141 bed acute care facility. We offer Acute Medical and Surgical Care, specializing in General Surgery, Oncology, General Internal Medicine, Cardiology, Respiratory Illnesses, and Major Orthopedic Services.

Upon release of this data, the Director of Utilization Review Services and the Director of Medical Record Services has validated this data, and with very few exceptions, we have found the data to be accurate.

The Medical Staff at Humana Hospital-Huntington Beach conducts an intensive review of the medical records of every patient who expires at this facility. This review concerns itself with the quality issues of medical management and overall care given to the patients at this facility. Quality review is an on-going process of the Quality Assurance Program, and this includes all aspects of care not only Mortality Review. Quality Assurance and Peer Review Activities are an integral part of the entire healthcare delivery system at this hospital.

Since some deaths occurred outside the hospital, we have been unable to completely validate this data. Unfortunately, in most cases the number of patients in a particular category is too small to provide a valid statistical analysis. In addition, the predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner, it would be inappropriate to consider them acceptable or unacceptable "standards".

Through the analysis of our Quality Assurance Program, we found that approximately 50% of the deceased patients listed in the Mortality Data Release Report were in a terminal stage of their diseases upon admission; and it was the patient's or family's choice to let the disease take its course and provide only comfort in their last days. These patients and/or families had made the decision to ask that no heroics be performed to prolong the patient's life and disease process.

Again, we thank you for the opportunity to present this response to this data release. If you or anyone receiving this information has additional questions or comments, please do not hesitate to call.

Sincerely,



Mark Anonson
Executive Director



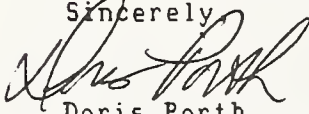
W. Raymond Menzies, MD
Chief of Staff

Humana Hospital San Leandro

RE: HOSPITAL MORTALITY INFORMATION

Thank you for the opportunity to comment on the hospital specific mortality data provided to us late last month. Humana Hospital - San Leandro supports the Health Care Financing Administration's desire to educate those interested in Medicare quality issues. We recognize this program is early in its development stages. While its measurements are preliminary and rough, it is clearly an example of the type of quality measurements to come. This information is helpful in our hospital's ongoing quality assurance program that includes regular and complete review of all admissions which result in patient mortality, regular quality assurance and utilization review, as well as complete outside review by the Joint Commission on Accreditation of Health Organizations and other outside review organizations. Since these raw numbers reflect deaths which occurred in only a limited segment of a hospital's patient population (the elderly) and are not adjusted for severity of illness or other factors which may effect patient outcome, they must be considered in that context and should serve as only one of numerous indicators used to review the quality of services provided at an individual hospital. While this statistical data is useful in this format for professional evaluation, it is not beneficial for consumer use. As a result, consumers should be informed as to the limited scope of these numbers, and be cautioned about drawing any conclusions from the data about the quality of a particular hospital's services. As in all deaths occurring in hospitals, a complete internal review is necessary to determine the appropriateness of the outcome and may provide information to physicians and other medical providers about improvements which can be made in treating future patients. Thus, the use of raw mortality statistics is helpful to professionals in identifying patient trends and treatment outcomes. Additionally, they may assist health care consumers in understanding the extensive quality control systems in place in hospitals. We have reviewed the data, since some deaths occurred outside the hospital, we have been unable to completely validate this data. Generally, we have found it to be consistent with our hospital records. Unfortunately, in most cases the number of patients in a particular category is too small to provide a valid statistical analysis. In addition, the predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner, it would be inappropriate to consider them acceptable or unacceptable "standards." I hope this information will be helpful in attempting to refine the collection and reporting of raw hospital data. In addition, our hospital will do everything possible to assist our community in understanding how this data can best be used to improve health care services.

Sincerely,



Doris Porth
Executive Director

200 Hospital Circle
Westminster, California
92683
Telephone 714 893 4541

+Humana Hospital Westminster

October 22, 1987

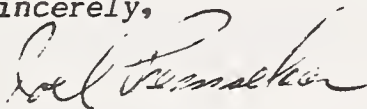
HCFA
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore MD 21207

Gentlemen:

Enclosed is our response to the mortality rate data provided us last month. Please include this response with data release information.

If you have any questions, please do not hesitate to contact me.

Sincerely,



Joel Prenselaar
Executive Director

JP:gc

HUMANA HOSPITAL-WESTMINSTER
RESPONSE TO HCFA MORTALITY RATE DATA FOR CALENDAR YEAR 1986
OCTOBER 1987

Thank you for the opportunity to comment on the mortality rate data provided last month. This information is helpful in our hospital's ongoing quality assurance program that includes complete review of all admissions which result in patient mortality, regular morbidity and mortality reviews, and utilization review. In addition to these internal reviews, external reviews of our hospital are periodically conducted by the Joint Commission on Accreditation of Health Organizations and other outside review organizations.

An extensive review was performed on the mortality cases identified by HCFA. As in all deaths occurring in hospitals, a complete internal review is always necessary to determine the appropriateness of the outcome and may provide information to physicians and other medical providers for reference in treating future patients. It must be noted the raw data provided by HCFA reflects deaths which occurred in a limited segment of the Hospital's patient population (the elderly), and the data is not adjusted for severity of illness, or other important factors affecting patient outcome. While the statistical data is useful in this format for professional evaluation, it is not beneficial for consumer use due to its limited scope, and the public should be cautioned about drawing any conclusions about the quality of services.

Humana Hospital-Westminster is an Orange County designated neuro-trauma center and a paramedic receiving center with a 16-bed ICU, expanded two years ago to meet increasing critical care needs. The cardiac care provided in the Emergency Room is recognized by the American Heart Associate for "First Hour" care. These critical care services increase the level of acuity of patients treated at the Hospital.

Our concern with the data provided by HCFA is that the predicted ranges of expected mortality do not reflect patient's severity of illness. Our detail medical record review of the 186 deaths identified by HCFA revealed a very high acuity level among the patients who died at Humana Hospital-Westminster. This is demonstrated by the following summary data:

- Of the 140 patients who died during their hospitalization, 109, or 77.86% had "Do Not Resuscitate" orders written in their medical record chart. A "Do Not Resuscitate" status indicates that the families of the patients and/or the patient themselves recognized the severity of the illness and made the decision to avoid heroic efforts in the event that the patient required cardiopulmonary resuscitation.

- One-hundred fifty-six (156), or 83.87% of these patients were admitted through the Hospital Emergency Room. This indicates the patients' medical problem was such that immediate attention was required.
- Fifty three (53), or 28.49% of the patients were admitted to the hospital from a skilled nursing facility. These are chronically ill patients whose condition had deteriorated to the point of requiring acute care.
- Seventy (70), or 37.63% of the patients were admitted to the Hospital's Intensive Care Unit; patients in this unit are so severely ill as to require life support and/or constant monitoring.

Also included in HCFA's mortality data are deaths which occurred 30 days after the patient's last hospital admission. Forty-six (46) of the deaths reported were patients still alive at the time of discharge. Since information concerning death after discharge is not included in medical records maintained by the Hospital, it is impossible for us to verify any influencing factors. In any event, deaths occurring after discharge are of questionable relevance to hospital mortality statistics. There is no assurance that the death was in any way related to the patient's most recent admission.

Humana Hospital-Westminster is in full support of accountability and measurability in hospital care and appreciates HCFA's efforts to achieve this. However, HCFA's statistical model, which has never been validated, presumes to estimate the risk of death based on quantitative characteristics. The inability of the HCFA data to include qualitative factors -- such as severity of illness, psychological factors, and socioeconomic factors -- limits its reliability.

Upon our extensive review, the omission of qualitative factors -- such as the patient's condition upon arrival to the Hospital -- and the inclusion of patients who died within 30 days after discharge, would explain any deviation from the predicted ranges calculated by HCFA.

We hope this information will be helpful in further refinement and reporting of raw hospital data.

Indian Valley District Hospital
Greenville, California

Provider Number: 05-0433

The hospital's comments consisted primarily of annotations to the patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish the comments because of the numerous patient identifiers contained in the data.



INLAND VALLEY REGIONAL MEDICAL CENTER

36485 Inland Valley Drive
Wildomar, California 92395

(714) 677-8671
(714) 674-1421

October 27, 1987

William L. Roper, M.D.
Administrator
Department of Health & Human Services
P.O. Box 26684
Baltimore, Maryland 21207

Dear Sir:

Thank you for this opportunity to respond to your current release of date on Hospital mortality rates.

First and foremost, mortality rates within all categories for our Hospital were within the range of predicated mortality. This, at first glance, could be seen as a very possitive indicator. However, we still believe there is very much more to be considered when analyzing a Hospital's quality of care. Although, your attempts to add meaningful criteria to the study have improved it's validity, there is much more that needs to be assessed before someone draws a conclusion regarding a Hospital's care. Such issues as previous treatment history, patient's choice of treatment, capabilities and intent of service, and other individual issues which alter or determine course of treatment.

Futhermore, in order for any study to be valid, it must contain sufficient numbers to show any given trend. Over half of the Diagnostic categories for our Hospital contain less than thirty (30) patients. For the above mentioned reasons we continue to approach this study with much apprehension.

Again, thank you for the opportunity to present this response. If you or anyone receiving this material have any questions, please do not hesitate to call me (714) 677-8671.

Sincerely,

Dan McLaughlin
Managing Director

DM/eb



Inter-Community Medical Center™

303 North Third Avenue, Covina, California 91722-5108

DUANE A. CARLBERG
EXECUTIVE VICE PRESIDENT/DIRECTOR

October 26, 1987

William L. Roper, M.D.
Administrator
Dept. of Health and Human Services
Washington, DC 20201

Re: Mortality Statistics
January 1 - December 31, 1986

Dear Dr. Roper:

Thank you for this opportunity to respond to the HCFA's release of data on hospital mortality rates for the calendar year 1986. Inter-Community Medical Center's staff has had an opportunity to review the data and has validated that, with minor exceptions, the data is accurate. As part of our quality assurance program, the Medical Staff conducts an intensive review of all expirations to assure the highest standard of medical management and patient care.

Based on the comprehensive review of the data and the specific medical records it reflects, we are confident that you and any member of the public who requests a copy of our statistical information will be interested in our summary report.

It is to be noted that in all categories, Inter-Community Medical Center's actual percentage of deaths remain well below the predicted percentage for our case mix and hospital size. It should also be noted that we are an acute care facility with major specialty areas of Oncology, Cardiac Surgery as well as General Medicine and Surgery.

The following summarizes our findings:

CA - CANCER

We are the primary Oncology treatment hospital for our area. Our mortality rate is 30% with a predicted range of 17-34%. It should be noted that:

- All patients were admitted in end stage disease process and a Do Not Resuscitate (DNR) request had been made by either the patient/family in all cases.

CE - CEREBROVASCULAR ACCIDENT (STROKE)

The predicted range of mortality for this category is 16-37%. Inter-Community Medical Center's rate is 25%. It should be noted that:

- The average age was 82, each patient had multiple disease complications.
- In each case, because of the severity of illness the family requested "DNR".

PRESIDENT
MICHAEL P. NEWMAN

VICE PRESIDENT
DARCY A. SKAGGS

TREASURER
ROBERT J. MILL

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GC - GASTROINTESTINAL CATASTROPHES

The predicted range of mortality for this category is 7 - 32%. Inter-Community Medical Center's rate is 14%. It should be noted that:

- All patients underwent surgery to attempt to relieve complex bowel obstruction or to correct G.I. bleeding secondary to evading cancer.
- The families of these patients had requested DNR.

HS - SEVERE ACUTE HEART DISEASE

The predicted range of mortality for this category is 26-50%. Inter-Community Medical Center's rate is 32%. It should be noted that:

- The majority of these patients had cardiac arrest at home, were non-responsive on admission to E.R., but did not respond to aggressive CPR.
- The remainder of the patients had Acute Myocardial Infarction with successful resuscitation, but experienced a subsequent "arrest" without responding to CPR.

HM - SEVERE CHRONIC HEART DISEASE

The predicted range of mortality for this category is 16-34%. Inter-Community Medical Center's rate is 19%. It should be noted that:

- All but 3 patients had longstanding cardiac problems and upon admission requested No Heroic measures.
- The remaining had one or more cardiac arrests during this hospitalization with successful resuscitation but finally succumbed secondary to extensive cardiac complications.

ME - METABOLIC AND ELECTROLYTE DISORDERS

The predicted range of mortality for this category is 8 - 35%. Inter-Community Medical Center's rate is 24%. It should be noted that:

- All patients had multiple acute and/or chronic disease and had a request by either the patient and/or family for "no heroic measures" to be done.

PN - PULMONARY DISEASE

The predicted range of mortality for this category is 14 - 29%. Inter-Community Medical Center's rate is 27%. It should be noted that:

- 85% of these patients had longstanding lung disease and had requested "no heroic measures".
- The remaining patients had multiple chronic medical problems with acute pulmonary disease which did not respond to aggressive therapy or they did not respond to aggressive CPR after heart attack.

RN - RENAL DISEASE

The predicted range of mortality for this category is 7 - 53%. Inter-Community Medical Center's rate is 40%. It should be noted that:

- All patients had multiple organ failure, all were dialyze, but family requested "No Code" in the event of a cardiac arrest.

SE - SEPSIS

The predicted range of mortality for this category is 18 - 63%. Inter-Community Medical Center's rate is 24%. It should be noted that all patients had underlying malignant neoplasms with complication of sepsis and were non-responsive to aggressive antibiotic therapy.

TR - SEVERE TRAUMA

The predicted range of mortality for this category is 2 - 20%. Inter-Community Medical Center's rate is 9%. It should be noted that the average age is 90 years. All experienced fractures prior to admission, had significant heart disease and their families had requested "No heroics".

EY - OPHTHALMOLOGIC DISEASE

It should be noted that Inter-Community Medical Center experienced no deaths in this category.

GY - GYNECOLOGIC DISEASE

It should be noted that Inter-Community Medical Center experienced no deaths in this category.

HL - LOW RISK HEART DISEASE

The predicted mortality range for this category is 2 - 7%. Inter-Community Medical Center's rate is 5%. It should be noted that the average age is 76. All patients had longstanding, but controlled cardiovascular disease. Each was admitted for acute complication of the disease process and did not respond to aggressive CPR.

GI - GASTROINTESTINAL DISEASE

The predicted mortality range for this category is 2 - 11%. Inter-Community Medical Center's rate is 5%. It should be noted that:

- 3 of the 5 patients had underlying malignant disease or were not a surgical candidate and had "no heroics" requested by their families.
- The remaining 2 patients had concurrent cardiac involvement, arrested but did not respond to aggressive CPR.

GU - UROLOGIC DISEASE

The predicted mortality range for this category is 1 - 15%. Inter-Community Medical Center's rate is 1%. It should be noted that due to the small number of patients, no response is presented to protect the privacy of family.

OP - ORTHOPEDIC CONDITIONS

The predicted mortality range for this category is 0 - 7%. Inter-Community Medical Center's rate is 1%. It should be noted that due to the small number of patients no response is presented to protect the privacy of the family.

William L. Roper, M.D.
Re: Mortality Statistics- Jan. 1 - Dec. 31, 1986
October 26, 1987
Page 4

UN - ALL OTHER CONDITIONS

The average age of patients in this category was 80. All patients except one had a request for "no heroic measures" or were admitted to Hospice. The remaining patient was 98 and had multiple organ failures.

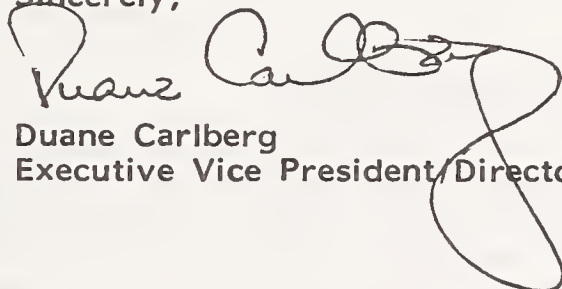
PATIENTS WHO EXPIRED OUTSIDE THE HOSPITAL BUT WITHIN 30 DAYS OF ADMISSION

It should be noted that 70% of these patients were residents of a convalescent home, were treated with resolution of acute medical problems and were transferred back to the convalescent home in stable condition. The remaining were discharged home in stable condition with visiting nursing care or with followup care at the physician's office.

The Medical Staff, as has been their practice, will continue to review all mortality cases on an individual basis. Trending analysis from these reviews is a constant endeavor to assist in identifying opportunities to improve care.

Thank you again for the opportunity to present this response.

Sincerely,

A handwritten signature in black ink, appearing to read "Duane Carlberg", with a large, stylized loop at the end.

Duane Carlberg
Executive Vice President/Director

DC/bp

cc: Paul Miller, M.D., Chief of Staff
Margaret Shea, California Medical Review, Inc.
Karen Logsdon, Senior Vice President
California Association of Hospitals and Health Systems

John F Kennedy Memorial Hospital

October 20, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

To whom it may concern:

John F. Kennedy Memorial Hospital [REDACTED] appreciates the opportunity to comment on the December release of hospital mortality information to the public.

A. DATA VERIFICATION

The data used by HCFA indicates that a total of 115 Medicare patients admitted to JFK Hospital in 1986 died within 30 days of admission. Three Medicare patients who were admitted in late December of 1985 died in 1986 within 30 days of discharge.

Our own records indicate that 1,581 Medicare admissions occurred at JFK Hospital. Presumably, the discrepancy reflects multiple admissions of individual beneficiaries to different hospitals. Because of this factor, we have no way of verifying whether the patient had been previously treated at another facility before the JFK Hospital admission. Our records indicate that of the 118 patients who died within 30 days of admission, 25 patients (21.2%) were alive at the time of discharge. It is not possible to ascertain the percentage of 25 patients dying after discharge who were in fact alive, as information concerning death after discharge is not included in the patient's medical record.

B. INTERPRETIVE REMARKS

In none of the sixteen diagnostic categories did JFK's actual mortality rate fall outside of the predicted mortality rate.

47-111 Monroe St., Drawer LLLL, Indio, California 92202-2588 • (619) 347-6191

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The mortality data also has a number of limitations which need to be recognized. They are as follows:

1. The predictive model does not consider all relevant factors. It includes only five patient characteristics:
 - o Age
 - o Sex
 - o Number of prior hospitalizations within the year
 - o Whether the patient was transferred from another hospital
 - o Whether the patient has other complicating illnesses
2. The model also does not include the following factors:
 - o Patient's general health status
 - o Stage of the patient's illness
 - o Psychological condition
 - o Does not accurately measure the quality of care. JFK Hospital believes mortality data should not be used to evaluate the quality of care at a given facility.
3. The model is based on a probability prediction interval and can only measure the chances of death.

C. UNIQUE SERVICES AT JFK HOSPITAL

JFK Hospital has a number of specialized services:

1. The only Level II (as designated by the American College of Surgeons) Oncology program in the Coachella Valley.
2. Complete radiology services including angiography.
3. A Level II emergency department which provides basic emergency services to the service area population. JFK Hospital treats trauma patients although it is not a trauma center.

In addition to the above, JFK Memorial's Case-Mix Index is 1.22. This relatively high case-mix index indicates that JFK Hospital has a complex patient base and treats patients with more acute conditions than would normally be the case in a 130-bed general acute care facility.

In conclusion, JFK Hospital once again appreciates the opportunity to comment on this information.

Sincerely,


Frederick W. Hodges
Chief Executive Officer

mh

cc: JFK Hospital Governing Board
Administrative Group Members



1601 Ygnacio Valley Road • Walnut Creek, California 94598-3194 • (415) 939-3000

October 21, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Please attach the following information to the Hospital Specific Report for calendar year 1986 prior to public disclosure for John Muir Medical Center (formerly called John Muir Memorial Hospital), Medicare provider #050180.

John Muir Medical Center is a 267-bed, acute care facility which treats patients with a variety of medical and surgical illnesses. John Muir is the only designated Trauma Center for Contra Costa County, and is a full service medical center, providing care in the following specialty areas: cardiovascular services including open-heart surgery, neurosciences including brain surgery, oncology (cancer) care, pulmonary (respiratory) services, orthopedic services and rehabilitation medicine. The medical center receives many of the most seriously ill and injured patients from throughout the County and surrounding areas.

John Muir Medical Center's primary concern is for the care of its patients. The John Muir Medical Staff extensively reviews the medical records of patients who die at the medical center to examine the appropriateness of medical treatment and overall care. In addition, the medical center reviews its own internal data, and trends in overall patient care and unexpected readmissions. The review of patient mortality is an on-going process of the John Muir Medical Center quality assurance program, which is an integral part of the monitoring of the medical center's entire healthcare delivery system.

The hospital-specific mortality data reported by the Health Care Financing Administration (HCFA) has been carefully reviewed by the John Muir Medical Center administrators, Chief of the Medical Staff, physicians and members of the Utilization Review and Quality Assurance Committees.

The HCFA mortality data report shows that John Muir Medical Center has a percentage of Medicare patient deaths well within the expected Range of Predicted Mortality Rates, both overall and in every diagnostic category. This range, determined by HCFA, classifies John Muir with hospitals/medical centers throughout the country treating patients similar in age, sex, medical history and condition.

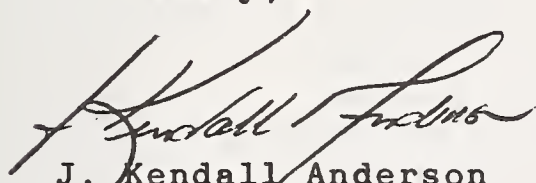
In a public release of information, HCFA made it clear that the mortality information on its own is not a complete measure of the quality of care at an individual hospital. William L. Roper, M.D., administrator HCFA, stated in a letter:

"While we believe that information on hospital mortality rates is useful, until we have developed additional statistical measures to deal with complex issues such as severity of illness, we cannot and do not recommend the use of the information by itself to make judgments about the quality of care in an individual hospital or to make comparisons among hospitals."

John Muir Medical Center reviews all aspects of care for every patient individually on an on-going basis, not just when statistics such as the patient mortality data are released. John Muir remains dedicated to providing patient care at the highest standards of quality.

Thank you for the opportunity to present this response.

Sincerely,



J. Kendall Anderson
President/Chief Executive Officer



Will H. Lane, M.D.
Chief of the Medical Staff

Mark S. Blumberg, M.D.
October 26, 1987

KAISER FOUNDATION HOSPITAL, ANAHEIM
STATEMENT REGARDING
HCFA MEDICARE MORTALITY STATISTICS RELEASED 1987
MEDICARE PROVIDER NO. 05-0609

As a group, the 28 Kaiser Foundation Hospitals (KFH), located in four states, had 39 mortality rates which were below the tolerance ranges predicted by HCFA while only 4 rates were above these predicted ranges. HCFA reported up to 17 mortality rates for each hospital, and the range for each was intended to include 95% of all hospitals. Thus by chance alone, 12 of the KFH mortality rates would be expected to be higher than HCFA's predicted ranges, with another 12 lower than these ranges.

This favorable 39 to 4 ratio of mortality statistics for KFH hospitals need little or no explanation. Nevertheless we are concerned by HCFA's use of risk models which cannot be critically evaluated at this time. Unaccountably, HCFA has not released sufficient data for an objective outside review of their method (e.g., no coefficients of variables in the models, no expected death rates). Despite this limitation, our preliminary review of the mortality risk adjustment models for 1986 Medicare discharges indicates serious problems which greatly reduce their value as useful measures of hospital care. One of the most apparent problems is due to the fact that nearly all the 16 disease categories contain principal diagnoses which differ greatly in their mortality rates. The 8 chronic comorbidities used as the key risk adjustors are not adequate to overcome these large differences. For this reason, hospitals can vary considerably in their risks, even after applying the models' adjustments. Some illustrations of omitted risk factors follow.

- CA - Cancer care cannot be judged from a single hospital episode, particularly when there are no risk factors to measure either the stage of the disease or whether the case was admitted for scheduled surgery. Admission for terminal care is certainly a key risk factor for cancer deaths, and this in turn depends on the availability of alternate sources of such care, for example hospice and home care programs. While admissions to HCFA-certified hospices were excluded from the 1986 discharge data, we believe that admissions to hospice units in short-term hospitals which had not sought HCFA approval were generally included, even when no charge for this care was made to HCFA. This would lead to inclusion of hospice cases at some hospitals and not at others.
- GI - Gastrointestinal disease includes the principal diagnosis of inguinal hernia (code 550). Most cases with this diagnosis are admitted for scheduled hernia repair surgery, which is very low in risk. However, some hernia cases are emergency admissions which are much higher in risk (e.g., strangulated hernias).
- HS - Severe acute heart disease is likely to be dominated by acute myocardial infarction, which is generally much lower in risk than other cases in this category (e.g., ruptured aortic aneurysm, cardiac arrest).
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The Kaiser Permanente Medical Care Program has a long record of interest and involvement in the development and use of methods to adequately risk adjust outcomes of hospital care for patients with diverse risks at admission. This year's HCFA analysis has incorporated many improvements which we suggested in our published critique of the HCFA outliers data released last year. We will continue to cooperate with HCFA and other responsible agencies in efforts to further improve these methods to make the findings more useful.



October 26, 1987

William Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Re: Kaiser Foundation Hospital, South San Francisco, California,
Provider No. 05-0070

Dear Dr. Roper:

The Kaiser Permanente Medical Care Program has a long record of interest and involvement in the development and use of methods to adequately risk adjust outcomes of hospital care for patients with diverse risks at admission. This year's HCFA analysis has incorporated many improvements which we suggested in our published critique of the HCFA outliers data released last year. We will continue to cooperate with HCFA and other responsible agencies in efforts to further improve these methods to make the findings more useful.

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This favorable 39 to 4 ratio of mortality statistics for KFH hospitals needs little or no explanation. Nevertheless we are concerned by HCFA's use of risk models which cannot be critically evaluated at this time. Unaccountably, HCFA has not released sufficient data for an objective outside review of their method (e.g., no coefficients of variables in the models, no expected death rates). Despite this limitation, our preliminary review of the mortality risk adjustment models for 1986 Medicare discharges indicates serious problems which greatly reduce their value as useful measures of hospital care.

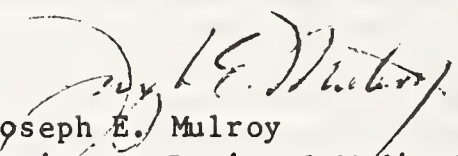
One of the most apparent problems is due to the fact that nearly all the 16 disease categories contain principal diagnoses which differ greatly in their mortality rates. The eight chronic comorbidities used as the key risk adjustors are not adequate to overcome these large differences. For this reason, hospitals can vary considerably in their risks, even after applying the models' adjustments.

Some illustrations of omitted risk factors follow:

- CA - Cancer care cannot be judged from a single hospital episode, particularly when there are no risk factors to measure either the extent of the disease or whether the case was admitted for scheduled surgery. Admission for terminal care is certainly a key risk factor for cancer deaths, and this in turn depends on the availability of alternate sources of such care, for example, hospice and home care programs. While admissions to HCFA-certified hospices were excluded from the 1986 discharge data, we believe that admissions to hospice units in short-term hospitals which had not sought HCFA approval were generally included, even when no charge for this care was made to HCFA. This would lead to inclusion of hospice cases at some hospitals and not at others.
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- TR - Severe trauma risk depends largely on the type, extent and combinations of injuries, none of which is distinguished by the risk model.

We are constantly seeking methods of improving patient care and welcome any assistance in developing better ways of monitoring our efforts.

Sincerely,


Joseph E. Mulroy
Assistant Regional Medical Centers
Administrator

We would like to coordinate further inquiries regarding this data through:

Daniel Danzig
Public Affairs
Kaiser Permanente Medical Care Program
1814 Franklin
Oakland, California 94612
(415) 428-6320

cc: J. Meresman



October 26, 1987

William Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Re: Kaiser Foundation Hospital, Santa Clara, California, Provider No. 05-0071

Dear Dr. Roper:

The Kaiser Permanente Medical Care Program has a long record of interest and involvement in the development and use of methods to adequately risk adjust outcomes of hospital care for patients with diverse risks at admission. This year's HCFA analysis has incorporated many improvements which we suggested in our published critique of the HCFA outliers data released last year. We will continue to cooperate with HCFA and other responsible agencies in efforts to further improve these methods to make the findings more useful.

Nationally, the 28 Kaiser Foundation Hospitals (KFH), located in four states, had 39 mortality rates which were below the tolerance ranges predicted by HCFA while only four rates were above these predicted ranges. HCFA reported up to 17 mortality rates for each hospital, and the range for each was intended to include 95% of all hospitals. Thus by chance alone, twelve of the KFH mortality rates would be expected to be higher than HCFA's predicted ranges, with another twelve lower than these ranges.

This favorable 39 to 4 ratio of mortality statistics for KFH hospitals needs little or no explanation. Nevertheless we are concerned by HCFA's use of risk models which cannot be critically evaluated at this time. Unaccountably, HCFA has not released sufficient data for an objective outside review of their method (e.g., no coefficients of variables in the models, no expected death rates). Despite this limitation, our preliminary review of the mortality risk adjustment models for 1986 Medicare discharges indicates serious problems which greatly reduce their value as useful measures of hospital care.

One of the most apparent problems is due to the fact that nearly all the 16 disease categories contain principal diagnoses which differ greatly in their mortality rates. The eight chronic comorbidities used as the key risk adjustors are not adequate to overcome these large differences. For this reason, hospitals can vary considerably in their risks, even after applying the models' adjustments.

Some illustrations of omitted risk factors follow:

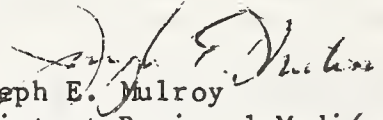
CA - Cancer care cannot be judged from a single hospital episode, particularly when there are no risk factors to measure either the extent of the disease or whether

the case was admitted for scheduled surgery. Admission for terminal care is certainly a key risk factor for cancer deaths, and this in turn depends on the availability of alternate sources of such care, for example, hospice and home care programs. While admissions to HCFA-certified hospices were excluded from the 1986 discharge data, we believe that admissions to hospice units in short-term hospitals which had not sought HCFA approval were generally included, even when no charge for this care was made to HCFA. This would lead to inclusion of hospice cases at some hospitals and not at others.

- GI - Gastrointestinal disease includes the principal diagnosis of inguinal hernia (code 550). Most cases with this diagnosis are admitted for scheduled hernia repair surgery, which is very low in risk. However, some hernia cases are emergency admissions which are much higher in risk (e.g., strangulated hernias).
- HS - Severe acute heart disease is likely to be dominated by acute myocardial infarction, which is generally much lower in risk than other cases in this category (e.g., ruptured aortic aneurysm, cardiac arrest).
- TR - Severe trauma risk depends largely on the type, extent and combinations of injuries, none of which is distinguished by the risk model.

We are constantly seeking methods of improving patient care and welcome any assistance in developing better ways of monitoring our efforts.

Sincerely,


Joseph E. Mulroy
Assistant Regional Medical Centers
Administrator

We would like to coordinate further inquiries regarding this data through:

Daniel Danzig
Public Affairs
Kaiser Permanente Medical Care Program
1814 Franklin
Oakland, California 94612
(415) 428-6320

cc: T. Seifert



October 26, 1987

William Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Re: Kaiser Foundation Hospital, Walnut Creek, California
Provider No. 05-0072

Dear Dr. Roper:

The Kaiser Permanente Medical Care Program has a long record of interest and involvement in the development and use of methods to adequately risk adjust outcomes of hospital care for patients with diverse risks at admission. This year's HCFA analysis has incorporated many improvements which we suggested in our published critique of the HCFA outliers data released last year. We will continue to cooperate with HCFA and other responsible agencies in efforts to further improve these methods to make the findings more useful.

Nationally, the 28 Kaiser Foundation Hospitals (KFH), located in four states, had 39 mortality rates which were below the tolerance ranges predicted by HCFA while only four rates were above these predicted ranges. HCFA reported up to 17 mortality rates for each hospital, and the range for each was intended to include 95% of all hospitals. Thus by chance alone, twelve of the KFH mortality rates would be expected to be higher than HCFA's predicted ranges, with another twelve lower than these ranges.

This favorable 39 to 4 ratio of mortality statistics for KFH hospitals needs little or no explanation. Nevertheless we are concerned by HCFA's use of risk models which cannot be critically evaluated at this time. Unaccountably, HCFA has not released sufficient data for an objective outside review of their method (e.g., no coefficients of variables in the models, no expected death rates). Despite this limitation, our preliminary review of the mortality risk adjustment models for 1986 Medicare discharges indicates serious problems which greatly reduce their value as useful measures of hospital care.

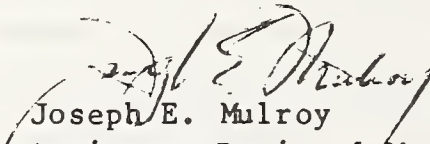
One of the most apparent problems is due to the fact that nearly all the 16 disease categories contain principal diagnoses which differ greatly in their mortality rates. The eight chronic comorbidities used as the key risk adjustors are not adequate to overcome these large differences. For this reason, hospitals can vary considerably in their risks, even after applying the models' adjustments.

Some illustrations of omitted risk factors follow:

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We are constantly seeking methods of improving patient care and welcome any assistance in developing better ways of monitoring our efforts.

Sincerely,


Joseph E. Mulroy
Assistant Regional Medical Centers
Administrator

We would like to coordinate further inquiries regarding this data through:

Daniel Danzig
Public Affairs
Kaiser Permanente Medical Care Program
1814 Franklin
Oakland, California 94612
(415) 428-6320

cc: K. Kentch



October 26, 1987

William Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Re: Kaiser Foundation Hospital, Vallejo, California, Provider No. 05-0073

Dear Dr. Roper:

The Kaiser Permanente Medical Care Program has a long record of interest and involvement in the development and use of methods to adequately risk adjust outcomes of hospital care for patients with diverse risks at admission. This year's HCFA analysis has incorporated many improvements which we suggested in our published critique of the HCFA outliers data released last year. We will continue to cooperate with HCFA and other responsible agencies in efforts to further improve these methods to make the findings more useful.

Nationally, the 28 Kaiser Foundation Hospitals (KFH), located in four states, had 39 mortality rates which were below the tolerance ranges predicted by HCFA while only four rates were above these predicted ranges. HCFA reported up to 17 mortality rates for each hospital, and the range for each was intended to include 95% of all hospitals. Thus by chance alone, twelve of the KFH mortality rates would be expected to be higher than HCFA's predicted ranges, with another twelve lower than these ranges.

This favorable 39 to 4 ratio of mortality statistics for KFH hospitals needs little or no explanation. Nevertheless we are concerned by HCFA's use of risk models which cannot be critically evaluated at this time. Unaccountably, HCFA has not released sufficient data for an objective outside review of their method (e.g., no coefficients of variables in the models, no expected death rates). Despite this limitation, our preliminary review of the mortality risk adjustment models for 1986 Medicare discharges indicates serious problems which greatly reduce their value as useful measures of hospital care.

One of the most apparent problems is due to the fact that nearly all the 16 disease categories contain principal diagnoses which differ greatly in their mortality rates. The eight chronic comorbidities used as the key risk adjustors are not adequate to overcome these large differences. For this reason, hospitals can vary considerably in their risks, even after applying the models' adjustments.

Some illustrations of omitted risk factors follow:

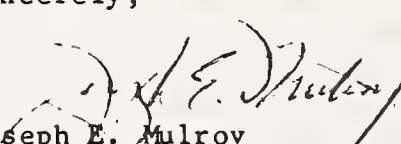
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the case was admitted for scheduled surgery. Admission for terminal care is certainly a key risk factor for cancer deaths, and this in turn depends on the availability of alternate sources of such care, for example, hospice and home care programs. While admissions to HCFA-certified hospices were excluded from the 1986 discharge data, we believe that admissions to hospice units in short-term hospitals which had not sought HCFA approval were generally included, even when no charge for this care was made to HCFA. This would lead to inclusion of hospice cases at some hospitals and not at others.

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Sincerely,


Joseph E. Mulroy
Assistant Regional Medical Centers
Administrator

We would like to coordinate further inquiries regarding this data through:

Daniel Danzig
Public Affairs
Kaiser Permanente Medical Care Program
1814 Franklin
Oakland, California 94612
(415) 428-6320

cc: S. Williams

Regional Medical Centers Administration
1924 Broadway
Oakland, California 94612
(415) 428-6242



October 26, 1987

William Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Re: Kaiser Foundation Hospital, Richmond, Provider No. 05-0074

Dear Dr. Roper:

The Kaiser Permanente Medical Care Program has a long record of interest and involvement in the development and use of methods to adequately risk adjust outcomes of hospital care for patients with diverse risks at admission. This year's HCFA analysis has incorporated many improvements which we suggested in our published critique of the HCFA outliers data released last year. We will continue to cooperate with HCFA and other responsible agencies in efforts to further improve these methods to make the findings more useful.

Nationally, the 28 Kaiser Foundation Hospitals (KFH) had 39 mortality rates which were below the tolerance ranges predicted by HCFA and only four rates above these predicted ranges. HCFA reported up to 17 mortality rates for each hospital, and the range for each was intended to include 95% of all hospitals. By chance alone, twelve of the KFH mortality rates would be expected to be above their predicted ranges, with another twelve below them.

This favorable 39 to 4 ratio of mortality statistics for KFH hospitals needs little or no explanation, but nevertheless we are concerned by HCFA's use of such problematic risk models. Unaccountably, as of this date HCFA has not released sufficient data for a critical review of their method (e.g., no coefficients of variables in the models, no expected death rates). Despite this limitation, our preliminary review of the mortality risk adjustment models for 1986 Medicare discharges indicates that they are very limited in value as useful measures of hospital care.

One of the apparent problems is due to the fact that nearly all the 16 disease categories contain principal diagnoses which differ greatly in their mortality rates, and for which the eight chronic comorbidities used as the key risk adjusters are inadequate. For this reason, hospitals can vary considerably in their risks without suitable adjustments by the model.

Some examples of statistical model problems with diagnostic categories follow:

Cancer (CA) care cannot be judged from a single hospital episode, particularly when there are no risk factors to measure either the extent of the disease or whether the case was admitted for scheduled surgery. Admission for terminal care is certainly a

key risk factor for cancer deaths, and this in turn depends on the availability of alternate sources of such care, for example, hospice and home care programs. While admissions to HCFA-certified hospices were excluded from the 1986 discharge data, we believe that admissions to hospice units in short-term hospitals which had not sought HCFA approval were generally included, even when no charge for this care was made to HCFA. This would lead to inclusion of hospice cases at some hospitals and not at others.

Gastrointestinal disease (GI) includes the principal diagnosis of inguinal hernia (code 550). Most cases with this diagnosis are admitted for scheduled hernia repair surgery, which is very low in risk. However, some hernia cases are emergency admissions which are much higher in risk (e.g., strangulated hernias).

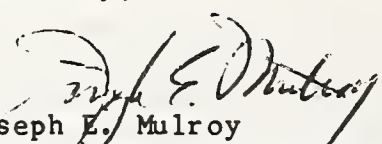
Severe acute heart disease (HS) is likely to be dominated by acute myocardial infarction, which is generally much lower in risk than other cases in this category (e.g., ruptured aortic aneurysm, cardiac arrest).

Severe trauma (TR) risk depends largely on the type, extent and combinations of injuries, none of which is distinguished by the risk model.

Analysis of our rates within the diagnostic categories shows that we exceeded the predicted range in the category of gastrointestinal catastrophes. The actual mortality rate was 100% with a predicted range of 1% to 89%. The number of cases which fell within this category was two and both patients expired. One patient was admitted for terminal care and in the second case, death was not an unexpected outcome.

We are constantly seeking methods of improving patient care and welcome any assistance in developing better ways of monitoring our efforts.

Sincerely,


Joseph E. Mulroy
Assistant Regional Medical Centers
Administrator

We would like to coordinate further inquiries regarding this data through:

Daniel Danzig
Public Affairs
Kaiser Permanente Medical Care Program
1814 Franklin
Oakland, California 94612
(415) 428-6320

cc: J. Rawls

Regional Medical Centers Administration
1924 Broadway
Oakland, California 94612
(415) 428-6242



October 26, 1987

William Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Re: Kaiser Foundation Hospital, Oakland, Provider No. 05-0075

Dear Dr. Roper:

The Kaiser Permanente Medical Care Program has a long record of interest and involvement in the development and use of methods to adequately risk adjust outcomes of hospital care for patients with diverse risks at admission. This year's HCFA analysis has incorporated many improvements which we suggested in our published critique of the HCFA outliers data released last year. We will continue to cooperate with HCFA and other responsible agencies in efforts to further improve these methods to make the findings more useful.

Nationally, the 28 Kaiser Foundation Hospitals (KFH) had 39 mortality rates which were below the tolerance ranges predicted by HCFA and only four rates above these predicted ranges. HCFA reported up to 17 mortality rates for each hospital, and the range for each was intended to include 95% of all hospitals. By chance alone, twelve of the KFH mortality rates would be expected to be above their predicted ranges, with another twelve below them.

This favorable 39 to 4 ratio of mortality statistics for KFH hospitals needs little or no explanation, but nevertheless we are concerned by HCFA's use of such problematic risk models. Unaccountably, as of this date HCFA has not released sufficient data for a critical review of their method (e.g., no coefficients of variables in the models, no expected death rates). Despite this limitation, our preliminary review of the mortality risk adjustment models for 1986 Medicare discharges indicates that they are very limited in value as useful measures of hospital care.

One of the apparent problems is due to the fact that nearly all the 16 disease categories contain principal diagnoses which differ greatly in their mortality rates, and for which the eight chronic comorbidities used as the key risk adjusters are inadequate. For this reason, hospitals can vary considerably in their risks without suitable adjustments by the model.

Analysis of our rates within the diagnostic categories shows that we exceeded the predicted range in two categories (cancer and sepsis). This data prompted a detailed review of the cases and the following summarizes our findings:

Cancer (CA) care cannot be judged from a single hospital episode, particularly when there are no risk factors to measure either the extent of the disease or whether the

case was admitted for scheduled surgery. Admission for terminal care is certainly a key risk factor for cancer deaths, and this in turn depends on the availability of alternate sources of such care, for example, hospice and home care programs. While admissions to HCFA-certified hospices were excluded from the 1986 discharge data, we believe that admissions to hospice units in short-term hospitals which had not sought HCFA approval (which is the case for our facility) were generally included, even when no charge for this care was made to HCFA. This would lead to inclusion of hospice cases at some hospitals and not at others. Case review indicates that 78% of our cancer patients who expired (65 out of 83) were admitted to our hospice unit.

Our case review for the diagnostic category of sepsis was particularly revealing. We found that patients had multiple complicating illnesses, many were transferred to our facility from nursing homes and death was not an unexpected outcome. In 50% of the case records, the multiple complicating illnesses were not coded on the Medicare bills (a similar lack of reporting of comorbidities was noted for pulmonary disease). This lack of information in the statistical formula led to a lower predicted mortality range.

Some illustrations of other omitted risk factors follow:

Gastrointestinal disease (GI) includes the principal diagnosis of inguinal hernia (code 550). Most cases with this diagnosis are admitted for scheduled hernia repair surgery, which is very low in risk. However, some hernia cases are emergency admissions which are much higher in risk (e.g., strangulated hernias).

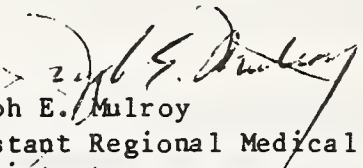
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Severe trauma (TR) risk depends largely on the type, extent and combinations of injuries, none of which is distinguished by the risk model.

We plan to work with both our medical staff and our medical records department to improve our documentation in the future.

We are constantly seeking methods of improving patient care and welcome any assistance in developing better ways of monitoring our efforts.

Sincerely,


Joseph E. Mulroy
Assistant Regional Medical Centers
Administrator

We would like to coordinate further inquiries regarding this data through:

Daniel Danzig
Public Affairs
Kaiser Permanente Medical Care Program
1814 Franklin
Oakland, California 94612
(415) 428-6320

cc: T. DeMartino

Regional Medical Centers Administration
1924 Broadway
Oakland, California 94612
(415) 428-6242



October 26, 1987

William Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Re: Kaiser Foundation Hospital, San Francisco, California, Provider No. 05-0076

Dear Dr. Roper:

The Kaiser Permanente Medical Care Program has a long record of interest and involvement in the development and use of methods to adequately risk adjust outcomes of hospital care for patients with diverse risks at admission. This year's HCFA analysis has incorporated many improvements which we suggested in our published critique of the HCFA outliers data released last year. We will continue to cooperate with HCFA and other responsible agencies in efforts to further improve these methods to make the findings more useful.

Nationally, the 28 Kaiser Foundation Hospitals (KFH), located in four states, had 39 mortality rates which were below the tolerance ranges predicted by HCFA while only four rates were above these predicted ranges. HCFA reported up to 17 mortality rates for each hospital, and the range for each was intended to include 95% of all hospitals. Thus by chance alone, twelve of the KFH mortality rates would be expected to be higher than HCFA's predicted ranges, with another twelve lower than these ranges.

This favorable 39 to 4 ratio of mortality statistics for KFH hospitals needs little or no explanation. Nevertheless we are concerned by HCFA's use of risk models which cannot be critically evaluated at this time. Unaccountably, HCFA has not released sufficient data for an objective outside review of their method (e.g., no coefficients of variables in the models, no expected death rates). Despite this limitation, our preliminary review of the mortality risk adjustment models for 1986 Medicare discharges indicates serious problems which greatly reduce their value as useful measures of hospital care.

One of the most apparent problems is due to the fact that nearly all the 16 disease categories contain principal diagnoses which differ greatly in their mortality rates. The eight chronic comorbidities used as the key risk adjusters are not adequate to overcome these large differences. For this reason, hospitals can vary considerably in their risks, even after applying the models' adjustments.

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GI - Gastrointestinal disease includes the principal diagnosis of inguinal hernia (code 550). Most cases with this diagnosis are admitted for scheduled hernia repair surgery, which is very low in risk. However, some hernia cases are emergency admissions which are much higher in risk (e.g., strangulated hernias).

HS - Severe acute heart disease is likely to be dominated by acute myocardial infarction, which is generally much lower in risk than other cases in this category (e.g., ruptured aortic aneurysm, cardiac arrest).

TR - Severe trauma risk depends largely on the type, extent and combinations of injuries, none of which is distinguished by the risk model.

We are constantly seeking methods of improving patient care and welcome any assistance in developing better ways of monitoring our efforts.

Sincerely,


Joseph E. Mulroy
Assistant Regional Medical Centers
Administrator

We would like to coordinate further inquiries regarding this data through:

Daniel Danzig
Public Affairs
Kaiser Permanente Medical Care Program
1814 Franklin
Oakland, California 94612
(415) 428-6320

cc: F. Alvarez

KAISER FOUNDATION HOSPITAL, PANORAMA CITY
STATEMENT REGARDING
HCFA MEDICARE MORTALITY STATISTICS RELEASED 1987

MEDICARE PROVIDER NO. 05-0137

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Mark S. Blumberg, M.D.
October 26, 1987

KAISER FOUNDATION HOSPITAL, LOS ANGELES
STATEMENT REGARDING
HCFA MEDICARE MORTALITY STATISTICS RELEASED 1987

MEDICARE PROVIDER NO. 05-0138

As a group, the 28 Kaiser Foundation Hospitals (KFH), located in four states, had 39 mortality rates which were below the tolerance ranges predicted by HCFA while only 4 rates were above these predicted ranges. HCFA reported up to 17 mortality rates for each hospital, and the range for each was intended to include 95% of all hospitals. Thus by chance alone, 12 of the KFH mortality rates would be expected to be higher than HCFA's predicted ranges, with another 12 lower than these ranges.

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Mark S. Blumberg, M.D.
October 26, 1987

**KAISER FOUNDATION HOSPITAL, BELLFLOWER
STATEMENT REGARDING
HCFA MEDICARE MORTALITY STATISTICS RELEASED 1987**

MEDICARE PROVIDER NO. 05-0139

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Mark S. Blumberg, M.D.
October 26, 1987

**KAISER FOUNDATION HOSPITAL, FONTANA
STATEMENT REGARDING
HCFA MEDICARE MORTALITY STATISTICS RELEASED 1987**

MEDICARE PROVIDER NO. 05-0140

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Mark S. Blumberg, M.D.
October 26, 1987

KAISER FOUNDATION HOSPITAL, HARBOR CITY
STATEMENT REGARDING
HCFA MEDICARE MORTALITY STATISTICS RELEASED 1987

MEDICARE PROVIDER NO. 05-0411

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Regional Medical Centers Administration
1924 Broadway
Oakland, California 94612
(415) 428-6242



October 26, 1987

William Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Re: Kaiser Foundation Hospital, Sacramento, California
Provider No. 05-0425

Dear Dr. Roper:

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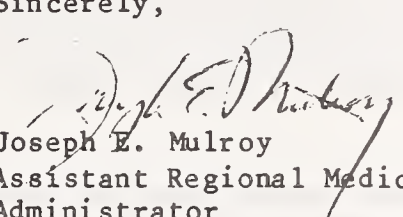
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Sincerely,


Joseph E. Mulroy
Assistant Regional Medical Centers
Administrator

We would like to coordinate further inquiries regarding this data through:

Daniel Danzig
Public Affairs
Kaiser Permanente Medical Care Program
1814 Franklin
Oakland, California 94612
(415) 428-6320

cc: J. Newman



October 26, 1987

William Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Re: Kaiser Foundation Hospital, San Rafael, California, Provider No. 05-0510

Dear Dr. Roper:

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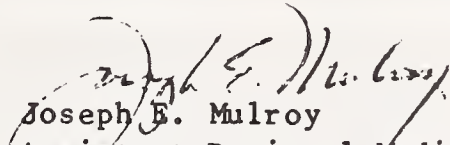
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Daniel Danzig
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1814 Franklin
Oakland, California 94612
(415) 428-6320

cc: P. Dowd

Regional Medical Centers Administration
1924 Broadway
Oakland, California 94612
(415) 428-6242



October 26, 1987

William Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Re: Kaiser Foundation Hospital, Hayward, California, Provider No. 05-0512

Dear Dr. Roper:

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We would like to coordinate further inquiries regarding this data through:

Daniel Danzig
Public Affairs
Kaiser Permanente Medical Care Program
1814 Franklin
Oakland, California 94612
(415) 428-6320

cc: I. Fawley

Mark S. Blumberg, M.D.
October 26, 1987

KAISER FOUNDATION HOSPITAL, SAN DIEGO
STATEMENT REGARDING
HCFA MEDICARE MORTALITY STATISTICS RELEASED 1987

MEDICARE PROVIDER NO. 05-0515

As a group, the 28 Kaiser Foundation Hospitals (KFH), located in four states, had 39 mortality rates which were below the tolerance ranges predicted by HCFA while only 4 rates were above these predicted ranges. HCFA reported up to 17 mortality rates for each hospital, and the range for each was intended to include 95% of all hospitals. Thus by chance alone, 12 of the KFH mortality rates would be expected to be higher than HCFA's predicted ranges, with another 12 lower than these ranges.

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Regional Medical Centers Administration
1924 Broadway
Oakland, California 94612
(415) 428-6242



October 26, 1987

William Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Re: Kaiser Foundation Hospital, Redwood City, California, Provider No. 05-0541

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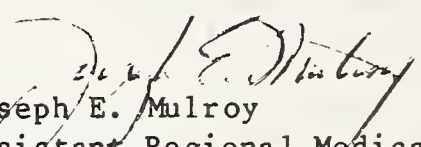
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HS - Severe acute heart disease is likely to be dominated by acute myocardial infarction, which is generally much lower in risk than other cases in this category (e.g., ruptured aortic aneurysm, cardiac arrest).

TR - Severe trauma risk depends largely on the type, extent and combinations of injuries, none of which is distinguished by the risk model.

We are constantly seeking methods of improving patient care and welcome any assistance in developing better ways of monitoring our efforts.

Sincerely,


Joseph E. Mulroy
Assistant Regional Medical Centers
Administrator

We would like to coordinate further inquiries regarding this data through:

Daniel Danzig
Public Affairs
Kaiser Permanente Medical Care Program
1814 Franklin
Oakland, California 94612
(415) 428-6320

cc: C. Kever

Mark S. Blumberg, M.D.
October 26, 1987

KAISER FOUNDATION HOSPITAL, WEST LOS ANGELES
STATEMENT REGARDING
HCFA MEDICARE MORTALITY STATISTICS RELEASED 1987

MEDICARE PROVIDER NO. 05-0561

As a group, the 28 Kaiser Foundation Hospitals (KFH), located in four states, had 39 mortality rates which were below the tolerance ranges predicted by HCFA while only 4 rates were above these predicted ranges. HCFA reported up to 17 mortality rates for each hospital, and the range for each was intended to include 95% of all hospitals. Thus by chance alone, 12 of the KFH mortality rates would be expected to be higher than HCFA's predicted ranges, with another 12 lower than these ranges.

This favorable 39 to 4 ratio of mortality statistics for KFH hospitals need little or no explanation. Nevertheless we are concerned by HCFA's use of risk models which cannot be critically evaluated at this time. Unaccountably, HCFA has not released sufficient data for an objective outside review of their method (e.g., no coefficients of variables in the models, no expected death rates). Despite this limitation, our preliminary review of the mortality risk adjustment models for 1986 Medicare discharges indicates serious problems which greatly reduce their value as useful measures of hospital care. One of the most apparent problems is due to the fact that nearly all the 16 disease categories contain principal diagnoses which differ greatly in their mortality rates. The 8 chronic comorbidities used as the key risk adjustors are not adequate to overcome these large differences. For this reason, hospitals can vary considerably in their risks, even after applying the models' adjustments. Some illustrations of omitted risk factors follow.

- CA - Cancer care cannot be judged from a single hospital episode, particularly when there are no risk factors to measure either the stage of the disease or whether the case was admitted for scheduled surgery. Admission for terminal care is certainly a key risk factor for cancer deaths, and this in turn depends on the availability of alternate sources of such care, for example hospice and home care programs. While admissions to HCFA-certified hospices were excluded from the 1986 discharge data, we believe that admissions to hospice units in short-term hospitals which had not sought HCFA approval were generally included, even when no charge for this care was made to HCFA. This would lead to inclusion of hospice cases at some hospitals and not at others.
- GI - Gastrointestinal disease includes the principal diagnosis of inguinal hernia (code 550). Most cases with this diagnosis are admitted for scheduled hernia repair surgery, which is very low in risk. However, some hernia cases are emergency admissions which are much higher in risk (e.g., strangulated hernias).
- HS - Severe acute heart disease is likely to be dominated by acute myocardial infarction, which is generally much lower in risk than other cases in this category (e.g., ruptured aortic aneurysm, cardiac arrest).
- TR - Severe trauma risk depends largely on the type, extent, and combinations of injuries, none of which is distinguished by the risk model.

The Kaiser Permanente Medical Care Program has a long record of interest and involvement in the development and use of methods to adequately risk adjust outcomes of hospital care for patients with diverse risks at admission. This year's HCFA analysis has incorporated many improvements which we suggested in our published critique of the HCFA outliers data released last year. We will continue to cooperate with HCFA and other responsible agencies in efforts to further improve these methods to make the findings more useful.

Regional Medical Centers Administration
1924 Broadway
Oakland, California 94612
(415) 428-6242



October 26, 1987

William Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Re: Kaiser Foundation Hospital, Martinez, California, Provider No. 05-0635

Dear Dr. Roper:

The Kaiser Permanente Medical Care Program has a long record of interest and involvement in the development and use of methods to adequately risk adjust outcomes of hospital care for patients with diverse risks at admission. This year's HCFA analysis has incorporated many improvements which we suggested in our published critique of the HCFA outliers data released last year. We will continue to cooperate with HCFA and other responsible agencies in efforts to further improve these methods to make the findings more useful.

Nationally, the 28 Kaiser Foundation Hospitals (KFH), located in four states, had 39 mortality rates which were below the tolerance ranges predicted by HCFA while only four rates were above these predicted ranges. HCFA reported up to 17 mortality rates for each hospital, and the range for each was intended to include 95% of all hospitals. Thus by chance alone, twelve of the KFH mortality rates would be expected to be higher than HCFA's predicted ranges, with another twelve lower than these ranges.

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One of the most apparent problems is due to the fact that nearly all the 16 disease categories contain principal diagnoses which differ greatly in their mortality rates. The eight chronic comorbidities used as the key risk adjustors are not adequate to overcome these large differences. For this reason, hospitals can vary considerably in their risks, even after applying the models' adjustments.

Some illustrations of omitted risk factors follow:

CA - Cancer care cannot be judged from a single hospital episode, particularly when there are no risk factors to measure either the extent of the disease or whether

the case was admitted for scheduled surgery. Admission for terminal care is certainly a key risk factor for cancer deaths, and this in turn depends on the availability of alternate sources of such care, for example, hospice and home care programs. While admissions to HCFA-certified hospices were excluded from the 1986 discharge data, we believe that admissions to hospice units in short-term hospitals which had not sought HCFA approval were generally included, even when no charge for this care was made to HCFA. This would lead to inclusion of hospice cases at some hospitals and not at others.

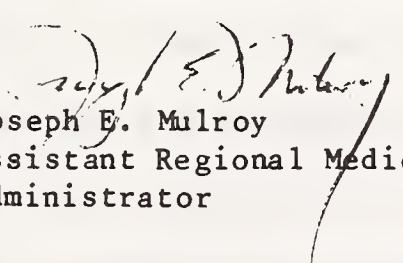
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We are constantly seeking methods of improving patient care and welcome any assistance in developing better ways of monitoring our efforts.

Sincerely,


Joseph E. Mulroy
Assistant Regional Medical Centers
Administrator

We would like to coordinate further inquiries regarding this data through:

Daniel Danzig
Public Affairs
Kaiser Permanente Medical Care Program
1814 Franklin
Oakland, California 94612
(415) 428-6320

cc: B. West

Mark S. Blumberg, M.D.
October 26, 1987

**KAISER FOUNDATION HOSPITAL, WOODLAND HILLS
STATEMENT REGARDING
HCFA MEDICARE MORTALITY STATISTICS RELEASED 1987**

MEDICARE PROVIDER NO. 05-0677

As a group, the 28 Kaiser Foundation Hospitals (KFH), located in four states, had 39 mortality rates which were below the tolerance ranges predicted by HCFA while only 4 rates were above these predicted ranges. HCFA reported up to 17 mortality rates for each hospital, and the range for each was intended to include 95% of all hospitals. Thus by chance alone, 12 of the KFH mortality rates would be expected to be higher than HCFA's predicted ranges, with another 12 lower than these ranges.

This favorable 39 to 4 ratio of mortality statistics for KFH hospitals need little or no explanation. Nevertheless we are concerned by HCFA's use of risk models which cannot be critically evaluated at this time. Unaccountably, HCFA has not released sufficient data for an objective outside review of their method (e.g., no coefficients of variables in the models, no expected death rates). Despite this limitation, our preliminary review of the mortality risk adjustment models for 1986 Medicare discharges indicates serious problems which greatly reduce their value as useful measures of hospital care. One of the most apparent problems is due to the fact that nearly all the 16 disease categories contain principal diagnoses which differ greatly in their mortality rates. The 8 chronic comorbidities used as the key risk adjustors are not adequate to overcome these large differences. For this reason, hospitals can vary considerably in their risks, even after applying the models' adjustments. Some illustrations of omitted risk factors follow.

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KAWEAH DELTA DISTRICT HOSPITAL

A NON PROFIT COMMUNITY DISTRICT HOSPITAL

400 W. Mineral King, Visalia, CA 93291

(209) 625-2211

THOMAS M. JOHNSON
EXECUTIVE DIRECTOR

October 26, 1987

Dr. William Roper, President
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
Post Office Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Re: Hospital Mortality Data
Medicare Provider #05-0057

Enclosed you will find a copy of our response to the Hospital Mortality Data. Thank you very much for the opportunity to provide these comments.

If you have any further questions, please feel free to call me at (209) 625-7329.

Sincerely,

KAWEAH DELTA DISTRICT HOSPITAL

Melanie M. Minarik
Director of Administrative Services

MMM:jac

Enclosure

FEDERAL EXPRESS

BOARD OF DIRECTORS

MURRELL D. TWIBELL
TREASURER

JAMES D. REESE
VICE PRESIDENT

JAMES L. MATHEWS
PRESIDENT

MAYNARD L. FAUGHT
SECRETARY

BYRON W. RIEGEL, M.D.
ASSISTANT SECRETARY



KAWEAH DELTA DISTRICT HOSPITAL

A NON PROFIT COMMUNITY DISTRICT HOSPITAL

400 W. Mineral King, Visalia, CA 93291

(209) 625-2211

THOMAS M. JOHNSON
EXECUTIVE DIRECTOR

October 23, 1987

Dear Health Care Consumer:

Kaweah Delta District Hospital (KDDH) appreciates the opportunity to respond to the Health Care Financing Administration's (HCFA) Mortality Data. The hospital takes pride in providing the standards of care that consumers have come to expect.

KDDH's mortality rates have fallen into the expected norms for our facility but this does not indicate that we agree with this method of releasing data for consumers to evaluate the quality of care. We urge you not to use this information in those terms but to point out the problems in using mortality data to evaluate the quality of care at any hospital.

These statistics, in fact, reflect mortality of patients that are Medicare patients (65 years of age and older) who, compared with other patients, are significantly more ill and have a higher death rate than the younger patients. In fact, there is no way to look at this data and be able to identify the individual ages in this group of patients. Perhaps they would be in ages of 80 to 90, for example, which with the high death rate, would create a false impression of the quality of care.

Secondly, certain hospitals treat more seriously ill patients than others. KDDH, for instance, is the main referral center between Fresno and Bakersfield and, therefore, sees more critically ill patients. Other hospitals and physicians refer high risk patients to us because of the number of our Medical Staff specialists, highly trained technical staff, and our advanced equipment. It is possible, then, that our particular hospital's death rate could be higher than the state or national rates because of the kinds of patients that we see. A low death rate could influence someone to go to a hospital which is not as fully equipped or staffed to provide the care needed for high risk patients. This data does not indicate where the patients came from or the severity of their problems. Many patients come to our Emergency Department in critical condition from skilled nursing facilities, other hospitals, or even from home in a terminal state. Again, this can reflect a higher death rate.

Thirdly, simple death rate statistics from any hospital do not indicate why a patient died. All deaths at KDDH are reviewed by each Clinical Department of our Medical Staff, monthly. California Medical Review, Inc. (the state-wide Professional Review Organization for Medicare) also reviews many of our deaths

BOARD OF DIRECTORS

MURRELL D. TWIBELL
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VICE PRESIDENT

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SECRETARY

BYRON W. RIEGEL, M.D.
ASSISTANT SECRETARY

CA 234.1

during the course of its monthly on-site reviews at our hospital. CMRI has yet to find any problems with the quality of care at our particular facility, and they have been reviewing us for the past three years.

In addition to all the above mentioned problems with this particular data, many of these patients, since they are older, have many medical problems even though they are admitted under one diagnostic category. Again, we emphasize, the only way to determine whether this particular death or particular mortality rate could be high or low is to examine each patient's medical record and evaluate individual circumstances.

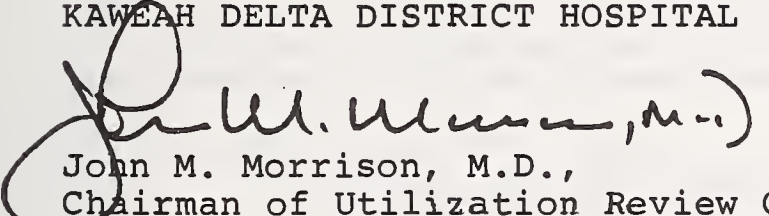
Aside from our opinion of death rates, William Roper, M.D., Administrator of HCFA says in his letter "While we believe that information on hospital mortality rates is useful, until we have developed additional statistical measures to deal with complex issues such as severity of illness, we can not and do not recommend the use of the information by itself to make judgments about the quality of care in an individual hospital or to make comparisons among hospitals." And this is the opinion of the organization releasing the data!

We appreciate the opportunity to comment on this data, and hope that if you have any further questions regarding it you will feel free to contact us at any time. We know that we at KDDH provide the highest quality of care.

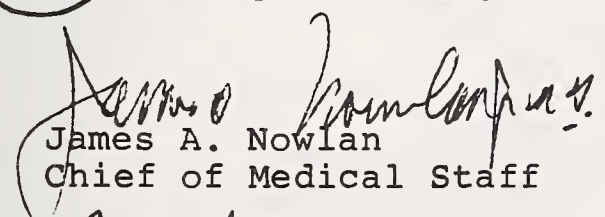
Further questions about this data should be directed to Melanie M. Minarik, Director of Administrative Services at (209) 625-7329.

Sincerely,

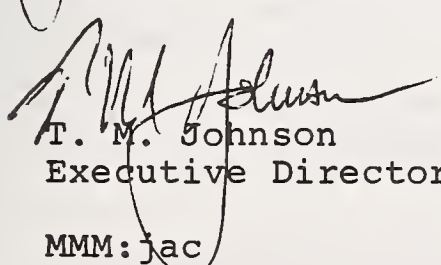
KAWEAH DELTA DISTRICT HOSPITAL



John M. Morrison, M.D.,
Chairman of Utilization Review Committee

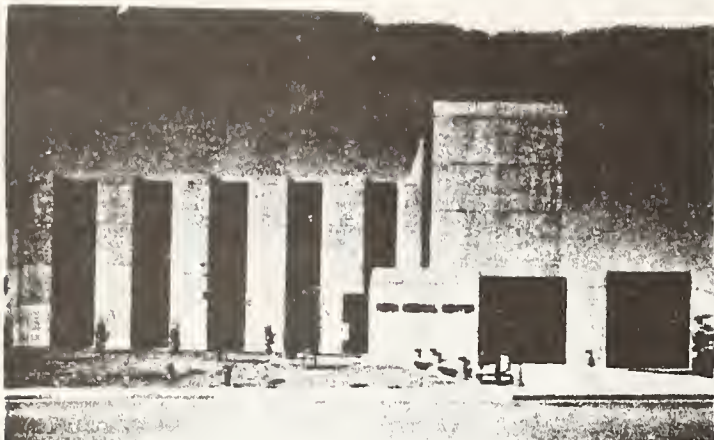


James A. Nowlan
Chief of Medical Staff



T. M. Johnson
Executive Director

MMM:jac



KERN MEDICAL CENTER

1830 FLOWER STREET, BAKERSFIELD, CALIFORNIA 93305-4197

TELEPHONE: (805) 326-2000

October 26, 1987

Department of Health & Human Services
Health Care Financing Administration
6325 Security Blvd.
Baltimore, Maryland 21207
ATTN: William L. Roper, M.D.

Dear Dr. Roper:

Thank you for the opportunity to respond to the release of data on hospital mortality rates for the year 1986. The following information for Kern Medical Center is to be attached to our 1986 HCFA mortality data prior to public disclosure.

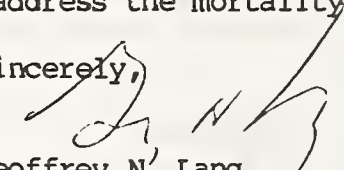
Kern Medical Center is a 243 acute care County, teaching facility. The case mix for this facility includes many patients with major medical and surgical illnesses. We are a referral center for many hospitals in the area and serve as a major trauma center.

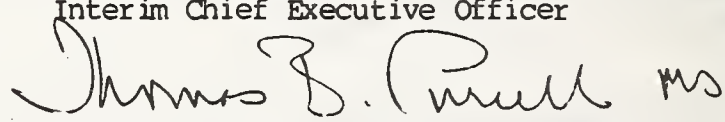
In all diagnostic categories Kern Medical Center's mortality rate fell within the Department of Health and Human Services predicated rate. Three diagnostic categories had zero percentages. Although, this mortality data did not reveal any adverse patterns, Kern Medical Center, through medical staff committees, will continue to review mortality cases for quality and appropriateness of care rendered to the individual patient.

The Quality Assurance Program and other peer review activities are an integral part of the monitoring of the health care delivery system at this hospital. Analysis from these reviews is a constant endeavor to assist in identifying opportunities to improve care.

Again thank you for the opportunity to address the mortality data.

Sincerely,


Geoffrey N. Lang
Interim Chief Executive Officer


Thomas B. Purcell, M.D., Chairman
Quality Assurance Committee

GNL:TBP:kag



DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES • HARBOR-UCLA MEDICAL CENTER
(213) 533-2101



WILLIAM H. SWANSON, M.D.
MEDICAL DIRECTOR

EDWARD J. FOLEY
HOSPITAL ADMINISTRATOR

October 26, 1987

William L. Roper, M.D., Administrator
Health Care Finance Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

RE: Mortality Statistics - Medicare Provider Number 050376

Dear Mr. Roper:

Thank you for this opportunity to respond to the release of data on hospital mortality rates.

Los Angeles County Harbor-UCLA Medical Center is a 553-bed acute care facility affiliated with the Medical School of the University of California at Los Angeles. We are the public hospital for a large portion of Los Angeles County, treating approximately 25,500 inpatients and 283,500 outpatients annually. As is the case with most public hospitals in large metropolitan areas, our Medi-Care patients are, on the average, sicker than Medi-Care patients admitted elsewhere and they have a greater number of secondary medical problems. Over 80% of our patients are admitted through the Emergency Room.

On an ongoing basis, clinical departments review every mortality in our facility for appropriateness of care. The following summarizes our findings in two categories that exceeded the predicted range.

1. Severe Acute Heart Disease

DRG #122 - Circulatory Disorders with Acute Myocardial Infarction without Cardiovascular Complications, Discharged Alive

DRG #123 - Circulatory Disorders with Acute Myocardial Infarction, Expired

The predicted percentage of deaths in this category was reported to be 21-57% and ours to be 71%.

1000 WEST CARSON STREET,
TORRANCE, CALIFORNIA 90509

It should be noted that:

- o This represents twenty (20) deaths during calendar year 1986.
- o All twenty were admitted in serious condition resulting from an acute myocardial infarction. Twelve patients were admitted from home and eight were transferred from a skilled nursing facility.
- o All twenty patients had additional medical problems that complicated their medical condition. These problems included congestive heart failure, a history of strokes, renal insufficiency, a history of coronary artery bypass surgery, anoxic encephalopathy without evidence of brain stem function, seizure disorder, renal failure, pneumonia, sepsis, electrolyte abnormalities, Parkinson's disease, anemia, hypertension, pulmonary edema, gastrointestinal bleeding, hypertrophic cardiomyopathy, cirrhosis of the liver, schizophrenia, and Alzheimer's disease.
- o Twelve of the twenty patients were placed on "No Code" status as requested by the family shortly after admission due to existing medical conditions noted above.
- o One of the twenty patients expired at another facility after being discharged in fair-to-stable condition with a poor prognosis.
- o The remaining seven patients experienced one or more cardiac arrests during their hospitalization and did not respond to aggressive therapy.

2. Urological Disease

DRG #320 - Kidney: Urinary Tract Infections, Age >69
and/or co-morbidity or complications.

DRG #321 - Kidney: Urinary Tract Infections, Age 18-69
without co-morbidity or complications.

The predicted percentage of deaths in this category was reported to be 1-22% and ours to be 24%.

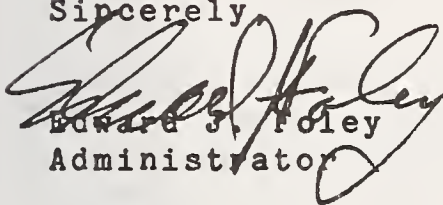
It should be noted that:

- o All eight patients were transferred from nursing homes in serious condition with multiple major medical problems, including pneumonia, a history of multiple strokes, seizure disorder, coronary artery disease, Parkinson's disease, congestive heart failure, anemia, renal failure, diabetes, septic shock, gastrointestinal bleeding, and chronic dementia, in addition to their primary admitting diagnosis.

- o Five of the eight patients were placed on "No Code" status at the request of the family.
- o The remaining three patients expired at other facilities after being discharged in fair-to-stable condition with a poor prognosis.

Again, thank you for the opportunity to present this response. If you or anyone receiving this information has additional questions, please do not hesitate to contact us at (213) 533-2101 or (213) 533-2901.

Sincerely,


Edward J. Foley
Administrator

EJF:WHS:tlz


William H. Swanson, M.D.
Medical Director



October 16, 1987

The Administrator
Department of Health & Human Services
Washington, D.C. 20201

Dear Sir:

In response to the recent inquiry solicited regarding the release of mortality statistics for short term acute hospitals, our comments are attached concerning this information. It is our intentions to have this comment included with our report concerning the reporting of the "metabolic/electrolyte disturbances" section (see attached).

Thank you very much.

Sincerely,

Marie Schubert

Marie Schubert, RRA
Medical Records Manager

HOSPITAL = 050580		LA PALMA HOSP MEDICAL CTR		BUENA PARK CA	
		DIAGNOSTIC CATEGORY	CASES	ACTUAL MORTALITY RATE	RANGE OF PREDICTED MORTALITY RATES
ALL	CAUSES		501	13 %	7 TO 15 %
CA	- CANCER		19	32 %	8 TO 46 %
CE	- CEREBROVASCULAR ACCIDENTS		22	27 %	11 TO 47 %
GC	- GASTROINTESTINAL CATASTROPHES		6	33 %	2 TO 64 %
GI	- GASTROINTESTINAL DISEASE		44	7 %	1 TO 16 %
GU	- UROLOGIC DISEASE		19	5 %	0 TO 31 %
GY	- GYNECOLOGIC DISEASE		7	0 %	0 TO 100 %
HL	- LOW-RISK HEART DISEASE		44	0 %	1 TO 15 %
HM	- SEVERE CHRONIC HEART DISEASE		28	11 %	10 TO 40 %
HS	- SEVERE ACUTE HEART DISEASE		13	77 %	16 TO 66 %
ME	- METABOLIC/ELECTROLYTE DISTURBANCES		4	100 %	4 TO 78 %
DP	- ORTHOPEDIC DISORDERS		23	4 %	0 TO 49 %
PN	- PULMONARY DISEASE		61	25 %	9 TO 30 %
RN	- RENAL DISEASE		9	44 %	7 TO 64 %
SE	- SEPSIS		6	17 %	10 TO 76 %
TR	- SEVERE TRAUMA		15	7 %	1 TO 37 %

75% survival rate reported
for hospitalizations

City and County of San Francisco



Department of Public Health
Laguna Honda Hospital

Laguna Honda Hospital
Medicare Provider #55-5020

October 26, 1987

Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

RE: HCFA Hospital Mortality Data

Dear Sirs:

Laguna Honda Hospital appreciates the opportunity to respond to the acute hospital mortality statistics which are to be published by the Health Care Financing Administration in December 1987. The data for our hospital have been carefully reviewed and are correct.

Although mortality rates by themselves do not provide information on quality of care, the data can be used to suggest areas in need of review. Laguna Honda Hospital, as part of its overall quality of care review, evaluates each death that occurs in the facility. In addition, other quality of care reviews, focusing on all aspects of medical, nursing and socio-behavioral care are routinely carried out through an active multidisciplinary staff process of review and analysis.

Laguna Honda Hospital is licensed as both an acute care hospital and a skilled nursing facility. While the majority of the 1068 patients at the hospital receive skilled nursing care, when an acute illness occurs, patients are transferred to the acute hospital component of the facility.

The Health Care Financing Administration data for Laguna Honda Hospital reflects the mortality rate in the relatively small number (119) of Medicare patients who were admitted to Laguna Honda's acute hospital from the skilled nursing facility. Of the 40 patients who died, most had at least two underlying conditions such as strokes, heart disease, kidney failure, diabetes or cancer, and they had been receiving skilled nursing care for these medical conditions for two to three years prior to the onset of their acute illness. The average age of the Laguna Honda patients who died was 82 years, whereas the average age of the patients in the facility is 77 years. Patients in the acute hospital of Laguna Honda are elderly and have significant medical conditions; in this population the mortality rates are expected to be higher than that in hospitals providing acute care to younger and healthier populations.

Laguna Honda Hospital strongly supports the goal of providing meaningful information to the public about the quality of health care. The process that HCFA has initiated is one step towards realizing this goal.

Sincerely,

A handwritten signature in cursive script, reading "Mary Anne Johnson".

Mary Anne Johnson, M.D.
Associate Administrator
for Medical Services

A handwritten signature in cursive script, reading "Larry Meredith".

Larry Meredith, Ph.D.
Acting Executive Administrator



Post Office Box 729 • 5176 Hill Road East, Lakeport, CA 95453 • 707/263-5651

W.H. Sellers
Administrator

October 20, 1987

To Health Care Consumers:

We have reviewed the mortality data for Medicare patients released by HCFA for calendar year 1986 and appreciate the opportunity to respond to the report dated September 21, 1987.

The Director of Medical Records has validated that the data is accurate and, in her capacity as Quality Assurance Coordinator, has reviewed all of the cases in the two categories in the upper ranges of normal - severe acute heart disease and pulmonary disease. Many of these cases involved individuals who had been ill for years and were on a continuum to the end stage of their disease. Some of these patients had requested that no life sustaining measures be instituted, i.e., cardiopulmonary resuscitation and/or ventilatory support.

If any deviations from recognized standards of care are identified during our program of on-going mortality review, they are addressed and corrective measures implemented. This occurs as an integral part of the hospital's quality assurance program, whereby each case of mortality in our facility is reviewed for appropriateness of care.

Sincerely,

W.H. Sellers
Administrator

WHS/kek





Little Company of Mary Hospital

4101 Torrance Boulevard, P.O. Box 2828
Torrance, California 90509 • (213) 540-7676

October 15, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Medicare Provider Number 050353

COMMENTS ON HCFA MORTALITY DATA

The data used by HCFA indicate that a total of 221 Medicare patients admitted to LCMH in 1986 died within 30 days of admission. Of these, 172 died while still a patient of the hospital and 49 died after discharge. Our records indicate that 2660 Medicare discharges occurred in 1986, which would indicate that our mortality rate based on those patients who died in the hospital setting is 6.4%.

It is impossible to determine the percentage of the 49 patients dying after discharge who were in fact alive, as information concerning death after discharge is not included in the medical record. In addition, the cause of death for these 49 patients cannot be determined and it may be unrelated to the principal diagnosis that resulted in the hospital admission. The following breakdown of patients who died after discharge highlights the diagnostic category for the admission:

<u>DIAGNOSTIC CATEGORY</u>	<u>NUMBER OF PATIENTS DYING AFTER DISCHARGE</u>	<u>PERCENTAGE OF TOTAL PATIENTS IN CATEGORY</u>
Cancer	5	20%
Cerebrovascular Accident	4	19%
Gastrointestinal Catastrophes	2	18%
Gastrointestinal Disease	1	17%
Urologic Disease	2	50%
Low-risk Heart Disease	6	36%
Severe Chronic Heart Disease	3	16%
Severe Acute Heart Disease	1	4%
Metabolic/Electrolyte Disturbances	4	40%
Pulmonary Disease	9	29%
Renal Disease	1	50%
Sepsis	1	6.7%
Trauma	0	0%
All Other Conditions	10	32%

Interpretation of Data

In none of the diagnostic categories does the hospital's actual mortality rate fall outside of the range of the predicted mortality rate. The overall mortality rate of 12% also does not exceed the range of predicted mortality rates of 9 to 16%.

Unique Services or Conditions Resulting in a Mortality Rate Over the Middle of the Range

The following diagnostic categories were reviewed in detail utilizing hospital data on the specific admission and our conclusions identify one of the problems in focusing on mortality rates as a measure of quality.

A. Cerebrovascular Accidents

This category includes diagnoses related to strokes and other major vascular problems. Of the twenty-one (21) patients who died, seventeen (17) were unresponsive and comatose when admitted to the hospital. Six of the patients were "no codes" and died in the hospital. The average age of the twenty-one patients was 78.43 years.

B. Sepsis

This category includes diagnoses related to major infections, usually with more than two sites of infection. Of the fifteen (15) patients who died, their underlying diagnoses included the following:

1. Acute and chronic congestive heart failure
2. Acute renal failure
3. Cancer
4. Acute bowel obstruction
5. Pneumonia

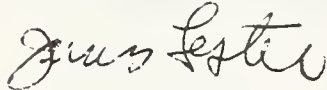
The average age of the fifteen patients was 85.13 years and 66% of the patients were admitted from a skilled nursing facility due to significant medical problems which could no longer be cared for in the non-acute facility.

RESULTS OF MEDICAL RECORD REVIEW

The patient records of all Medicare mortalities were reviewed and the deaths in the high risk categories were not unexpected. In the ten high risk categories, LCMH did not exceed the range of predicted mortality rates in any area. In two categories, cancer and cerebrovascular accidents, our severity factors are noted above. In the six low risk categories, LCMH was on the low end of the range and in three areas, ophthalmologic disease, gynecologic disease and urologic disease, we had no mortalities.

LCMH carries out quality review activities on all patients. The hospital and Medical Staff focus on any problem areas where patient care can be improved. All mortalities are included in the review process. California Medical Review reviews thirty to forty percent of all Medicare discharges and focuses on mortality, readmissions and other quality indicators. In these reviews, the mortality rate has not been identified as a significant factor in the quality of care. LCMH continues to utilize the data provided by HCFA, CMRI and our own reviews to identify any patterns of care that could be improved.

Sincerely,

A handwritten signature in cursive script, appearing to read "James Lester".

James Lester
President



**Community
Hospital
Of Lodi**

800 South Lower Sacramento Road
Lodi, California 95242

(209) 333-0211

October 27, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

Enclosed please find the analysis of Community Hospital of Lodi's HCFA
Mortality Data as reported in your letter of September 21, 1987.

Sincerely,

James T. Lasiter, Administrator

JTL:so
Encl.



800 South Lower Sacramento Road
Lodi, California 95242

(209) 333-0211

HCFA Mortality Data Analysis

Data Verification

The data used by HCFA indicate that a total of 56 Medicare patients admitted to Community Hospital of Lodi died within 30 days of admission. Of these, 45 died while still a patient of the hospital while 11 died after discharge. Our own records indicate that 721 Medicare admissions occurred in 1986. Our own records also indicate that, of the 45 Medicare patients who died within 30 days of admission while still an inpatient, 11 were still alive at the time of discharge. It is impossible to determine the percentage of the 11 patients dying after discharge who were in fact alive, as information concerning death after discharge is not included in the patient's medical record.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

Interpretive Remarks

In none of the diagnostic categories, did the hospital's actual mortality rate fall outside of the range of the predicted mortality rate. In 10 of the 16 diagnostic categories, the actual deaths, even including those who died after discharge from the hospital, were in the lower half of the range predicted. Of the remaining 6 diagnostic categories, the mortality rate experienced ranged only from the 55th to the 76th percentile of the predicted range. It is therefore felt the hospital care rendered by the medical staff and hospital employees is of high quality.

Results of Preliminary Medicare Record Review

Five of those 11 patients who died after discharge from the hospital had "No code" or "Do not resuscitate" orders while in the hospital, yet got well enough to be discharged. This indicates the physician and patient's family had anticipated probable death and agreed to take no heroic resuscitation measures if the patient reached a terminal episode. One of the 11 patients left the hospital Against Medical Advice and subsequently expired. The remaining five of the 11 all had various diseases of the heart for which death was not an unexpected outcome. All eleven of these deaths after discharge are therefore considered to be within the predictable range, as is borne out by the report results.

JTL:so



October 26, 1987

William L. Roper, M.D., Administrator
Health Care Finance Administration
Department of Health and Human Resources
Washington, D.C. 20201

RE: Mortality Statistics - January 1 - December 31, 1986

Dear Dr. Roper:

Thank you for the opportunity to respond to the data concerning mortality rates at Lodi Memorial Hospital prior to releasing the information to the public.

Lodi Memorial Hospital is a 99 bed acute care facility, whose care mix includes many patients requiring major medical and/or surgical treatment.

The data for mortality rates at Lodi Memorial Hospital for January 1 through December 31, 1986 have been carefully reviewed by appropriate members of our staff and have been determined to be accurate for the most part. In all cases, the statistical data for Lodi Memorial Hospital falls well within the predicted mortality range as determined by the Health Care Financing Administration. The three areas we have chosen to highlight are those which fall closest to the high end of the predicted range.

Of the 1,300 medicare patients admitted to our hospital in 1986, 136 or 10% resulted in hospital deaths. The report shows the actual mortality rate to be 15%, or 191 patients. Of these, our Director of Quality Assurance validates that 136 occurred in the hospital; 55 of the 191 deaths occurred following discharge at some other location, either a long term care facility or at home. Many were terminal and requested to go home.

In concurrence with good practice, every patient mortality that occurs at Lodi Memorial Hospital is reviewed on an ongoing basis by the medical staff department. With this continuous feedback we are able to improve our quality of care.

The HCFA study reveals Lodi Memorial Hospital to be close to the high end of the range of predicted mortality rates in three areas, each of which is considered to be a high risk diagnostic category. They are: GI (gastrointestinal disease); HM (severe chronic heart disease) and HS (severe acute heart disease).

Our findings regarding these areas are listed below:

HS - Severe Acute Heart Disease

The predicted range of mortality rates is 27% to 55%. Ours as reported is 51%. This represents 24 patients of which 3 died after discharge from the hospital bringing the actual mortality rate to 45%. The average age of all 24 patients in this category was 78 years of age.

MH - Severe Chronic Heart Disease

The predicted range of mortality rates for this category is 13% to 33%. As reported, ours was 31% representing 19 patients. Six of these 19 patients died outside the hospital bringing the actual mortality rate down to 20%. The average age of all 19 patients in this category was 75 years of age.

GI - Gastrointestinal Disease

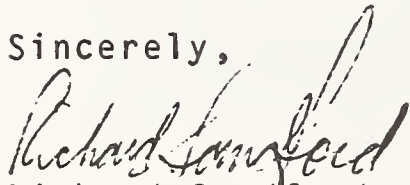
The predicted range of mortality for this category is 2% to 11% and ours as reported was 11% representing 15 patients. Five of these patients died after discharge, bringing the actual mortality rate to 7%. The average age of all 15 patients was 74 years of age.

While a good tool to assist in identifying opportunities to improve care, the mortality statistics for Lodi Memorial Hospital do not reveal anything out of the ordinary and are perfectly in line with the age and acuity of the patients seen here.

The Medical Staff of Lodi Memorial Hospital, as has been their practice, will continue to review all mortality cases for quality and appropriateness of care given to the individual patient. Trending analysis from these reviews is part of our constant endeavor to identify opportunities for improving care.

Again, thank you for the opportunity to share our findings with you and other appropriate groups.

Sincerely,


Richard Sandford
Administrator

RS:BH:jb

LOMA LINDA COMMUNITY HOSPITAL

A MEMBER OF ADVENTIST HEALTH SYSTEM LOMA LINDA

October 26, 1987

William L. Roper, MD
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Doctor Roper:

Thank you for this opportunity to respond to HCFA's current release of data on hospital mortality rates. Enclosed you will find comments from Loma Linda Community Hospital regarding this data that should be attached to our hospital specific report each time it is released.

Again, thank you for the opportunity to present this response. If you or anyone receiving this information have additional questions, please do not hesitate to call me at (714) 796-6613.

Sincerely,



Ron K. Benfield
Vice President for Finance

LOMA LINDA COMMUNITY HOSPITAL

A MEMBER OF ADVENTIST HEALTH SYSTEM LOMA LINDA

October 26, 1987

RE: Health Care Financing Administration (HCFA) Mortality
Data Release

To Whom It May Concern:

Loma Linda Community Hospital (LLCH) wishes to comment on the contents of the data that is being provided to you by HCFA. Although we are very pleased with the positive results the reports reflects upon our facility it is important to stress that the summary of data presented is only useful if one has a full understanding of its scope and limitations.

In reviewing this data it is important to keep the following factors in mind:

1. Incomplete or Inaccurate Data - The information HCFA provided may not include a 100% sample of all patient admitted in 1986 who died within in 30 days of hospital discharge or during hospitalization. Deaths occurring after the end of the first month of 1987 were excluded from the report.

Also, our records indicate that one patient had not expired at our facility as the report indicates.

2. Level of Acuity - Loma Linda Community Hospital is closely related to Loma Linda University Medical Center (LLUMC), a 546 bed tertiary care center. Due to the dual affiliation at both facilities of our medical staff, many of our patients are much sicker and require a much higher level of care than patients traditionally seen at a community hospital of our size.

3. Internal Peer Review System - All deaths at LLCH are screened for quality assurance purposes as dictated by the physicians. This is done in order to insure that even though a death has occurred that the patient was given appropriate and adequate medical attention.

In addition, the following general thought may provide some assistance in explaining apparent variations from the norms had they existed:

1. Death rates do not indicate why a patient dies. The way one determines whether or not a death in the hospital could have been avoided, is to examine each patient's medical record to discover individual circumstances.
2. The data does not take into account the severity of the individual patient's injury or illness. Patients in critical conditions from accidents and patients who are terminally ill are included in the data. When admitted to the hospital, the patient may be barely alive with a poor prognosis.
3. Patients may have more than one medical problem. Many patients do not die from the principal diagnosis. But the data presented by HCFA will not reflect multiple, contributing complications of death.
4. The data does not reflect where the patients came from and patients admitted through the emergency room are generally more high risk candidates than others. Patient admitted from nursing homes tend to be sicker than those admitted who are still able to care for themselves at home.
5. Certain hospitals generally treat more seriously ill patients than other hospitals. Hospitals associated with teaching hospitals and special units of some hospitals receive high risk cases from other hospitals because they have the necessary high technology equipment and experienced physicians to provide extraordinary care. It is logical that these hospitals would have a higher death rate in some categories. A low death rate at a particular hospital may influence consumers to seek care at a hospital that is not fully equipped or fully staffed to provide care for high risk patients.
6. The number of patients within a particular diagnostic category will greatly influence the death rate percentage. The smaller the number of patients in the category, the more likely the number is subject to misinterpretation.
7. Although the information published applies only to Medicare, it can create false impressions of the overall quality of care at hospitals.

Respectfully submitted,

Ron K. Benfield

Ron K. Benfield
Vice President for Finance

Loma Linda University Medical Center

11234 Anderson St. • P.O. Box 2000 • Loma Linda, CA 92354 • 714-796-7311

WRITER'S DIRECT DIAL NUMBER

October 22, 1987

William L. Roper, M.D.
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Dr. Roper:

Thank you for the opportunity to respond to HCFA's release of data on hospital mortality rates for 1986. Since receiving the report a number of staff members at Loma Linda University Medical Center (LLUMC) have had an opportunity to review the data. It is generally accepted that mortality data does not necessarily reflect the quality of care provided. It should be pointed out that in several of the diagnostic groups the number of discharges is sufficiently low to make statistical significance indeterminable. Drawing conclusions from the compiled statistics might be misleading if certain factors are not considered and we would like to focus on several of these:

The mortality data does not take into account the severity of the individual patient's injury or illness. Loma Linda University Medical Center is the only state-designated level I regional trauma center for the four inland counties, and as such, treats a high proportion of critically ill patients with severe injuries, often transferred from other facilities. Trauma victims often have multiple injuries and are known to have a higher risk of post operative complications.

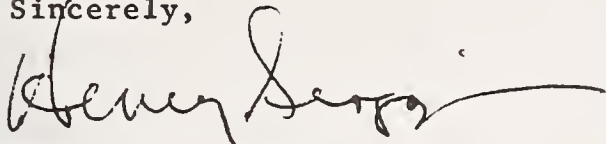
Tertiary care referral hospitals generally treat more seriously ill patients than other hospitals. Teaching facilities such as LLUMC receive a large proportion of high-risk patients, often transferred from other hospitals, because we have the necessary technologically advanced equipment and specially skilled staff to provide extraordinary care. Often these patients have multiple medical problems, and therefore, a higher risk for morbidity and mortality.

Loma Linda University Medical Center's Respiratory Intensive Care Unit accepts a large proportion of ventilatory-dependent patients in transfer from referring hospitals throughout four inland counties.

A Seventh-day Adventist Institution

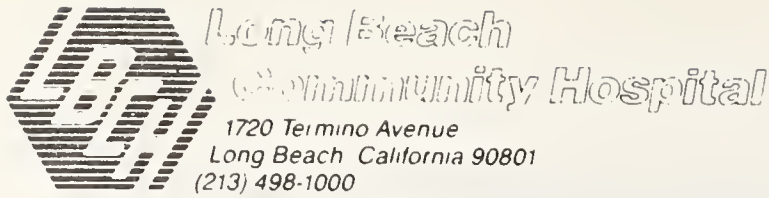
Thank you once again for the opportunity to clarify the mortality data. If you or anyone receiving this information have additional questions, please do not hesitate to contact Dick Schaefer, Director of Community Relations at (714) 824-4419.

Sincerely,

A handwritten signature in dark ink, appearing to read "T. Henry Scoggins", with a long horizontal flourish extending to the right.

T. Henry Scoggins
Executive Vice President
Loma Linda University Medical Center
P.O. Box 2000
Loma Linda, California 92354

dp



October 23, 1987

LONG BEACH COMMUNITY HOSPITAL
MEDICARE PROVIDER # 050170

The following information for Long Beach Community Hospital is to be attached to the Hospital Specific Report for the period January 1 through December 31, 1986, prior to public disclosure.

Long Beach Community Hospital is a 300-bed acute care facility whose case mix includes many patients with major medical and surgical illnesses. It is a full service institution offering specialized care in the fields of cancer, open-heart surgery, major orthopedic services, rehabilitation medicine, as well as general medicine and surgery. The hospital is accredited by the Joint Commission on the Accreditation of Hospitals and the California Medical Association. In addition, the American College of Surgeons has accredited the cancer program. The hospice program, with its tie to the terminally ill, is an area of particular pride to the hospital.

As part of the ongoing monitoring of the quality of care and services, the Quality Assurance program of Long Beach Community Hospital routinely conducts an extensive review of all mortalities. Each patient is the focus of study rather than a statistical rate. Although it is recognized there is no direct correlation between mortality rates and quality of care, the medical staff continues to review all cases for appropriateness of care rendered to the individual patient.

The hospital's specific mortality data report by HCFA has been carefully reviewed by the hospital Chief Executive Officer, Medical Director, and Directors of Utilization Management, Quality Assurance, and Medical Records. Long Beach Community Hospital was within or below the predicted percentage of mortality in all categories according to this data release. However, this is the third format used by HCFA in the past two years to present mortality statistics and the validity of data is still questionable. HCFA's predicted mortality rates still do not adequately adjust for severity of illness, a very important factor in the meaningful evaluation of mortality statistics.

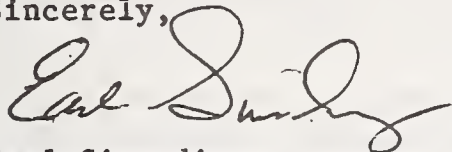
an affiliate of HealthWest[®], a nonprofit network in pursuit of excellence

This particular data release also credits the hospital with deaths occurring after release from the hospital and automatically attributes the cause of death as identical to the hospital diagnosis. Of the deaths listed, nineteen percent (19%) died after leaving the hospital. Each of these patients met the Medicare discharge criteria for a safe discharge at the time they left the hospital. Therefore, connecting their deaths with their hospital care is questionable. The hospital also does not have any way to check the validity of HCFA's statistics regarding deaths occurring outside the hospital or to learn the true cause of death. Therefore, no analysis is possible.

As previously stated, review of care is always done by individual case regarding overall quality and appropriateness of care. It is conducted in an ongoing manner by medical and administrative staff, not just when statistics such as the mortality data are released. Any reviewer of data should carefully note the limitations of the summary data. Differences in statistical data between hospitals should not be interpreted as differences in quality of care. More likely these differences reflect differences in severity of illness and individual hospital patient mix.

We appreciate the opportunity to respond to the data. If anyone receiving this information has additional questions, please contact me.

Sincerely,



Earl Simendinger
Chief Executive Officer

/wg



LONG BEACH
Doctors Hospital

October 20, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Re: Comments On HCFA Mortality Data

Data Verification:

The data used by HCFA indicate that of a total of 289 Medicare patients admitted to Long Beach Doctors Hospital, 26 died within 30 days of admission. Of these, 18 died while still a patient of the hospital, while 8 died after discharge. Our own records indicate that of the 26 Medicare patients who died within 30 days of admission, 9 were still alive at the time of discharge. Of those patients alive at the time of discharge, 7 died in extended care facilities and 2 died at home.

Without complete information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in the analysis of mortality rates. In the majority of the diagnostic categories chosen by HCFA, the volume of patients treated at Long Beach Doctors Hospital is not high enough to be statistically meaningful.

Interpretive Remarks:

In only one of the diagnostic categories, Long Beach Doctors Hospital's actual mortality rate falls outside the predicted mortality rate. In this high risk diagnostic category (severe acute heart disease), only one Medicare patient was treated. This one patient was 80 years of age and had several serious comorbidities including chronic congestive heart failure. The patient did expire as was considered likely at the time of admission. Therefore, the reported mortality rate is 100% for this diagnostic category. This mortality rate is misleading as only one Medicare patient was treated for severe acute heart disease.

Contact: Joe Reifert
Director of Marketing
(213) 599-3551

1725 PACIFIC AVE., LONG BEACH, CA 90813 (213) 599-3551



Los Alamitos Medical Center

NICHOLAS V. McCLURE
Executive Director

October 26, 1987

William L. Roper, M.D.
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for giving us the opportunity to respond to the HCFA data concerning mortality rates in our hospital. Los Alamitos Medical Center is dedicated to providing the highest possible quality of care and our Medical Staff, as well as the hospital departments, have implemented comprehensive quality assurance systems to monitor the care given at the facility. Following are specific and general comments relating to the statistics for this facility:

1. EY - Ophthalmologic Disease: In this case we had one (1) case which resulted in a mortality rate of 100%. Investigation reveals that the cause of death was related to a stroke and occurred four (4) days after discharge.
2. HS - Severe Acute Heart Disease: While we are within the range of predicted mortality rates for this diagnostic category, due to the higher age of the patients we serve and the severity of illness in these cases, we would expect to see a higher ratio of deaths occurring in this category.
3. PN - Pulmonary Disease: While we are within the range of predicted mortality rates for this diagnostic category, our findings indicate that the older population served by us are usually compromised by other disease processes and the deaths in this category are usually related to other unrelated contributing factors.
4. RN - Renal Disease: While we are within the range of predicted mortality rates for this diagnostic category, our investigation revealed that these patients normally have multi-system problems of a severe nature and the deaths are usually related to underlying complications of other disease processes.

3751 Katella Avenue, Los Alamitos, California 90720 (213) 598-1311 - (714) 826-6400

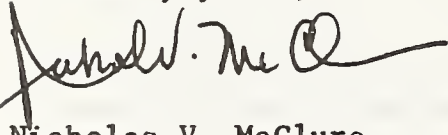
A National Medical Enterprises Health Care Facility

William L. Roper, M.D.
October 26, 1987
Page Two

5. Los Alamitos Medical Center serves a high proportion of the older population due to our proximity to a retirement community of approximately 9,000 residents located five miles from the hospital. These patients often are admitted with multiple problems unrelated to the primary diagnosis. However, the average age of the community is now 77.6 compared to 74.0 fifteen years ago which certainly is an indicator of the overall quality of medical care provided to these patients.
6. We also would like to comment on the reporting of deaths which occur outside the facility after discharge. We would like to have the opportunity to research these in more detail, however, due to confidentiality constraints and other factors, we recognize that this is not practicable. However, it should be noted that in these cases, the death may be totally unrelated to the hospital admission.

Once again, thank you for giving us this opportunity to respond. We are always willing to discuss our quality of care and services.

Sincerely yours,



Nicholas V. McClure
Executive Director

NVM:s1
32/010

**Department of Health Services
Los Angeles County - University of Southern California
Medical Center**

J. L. BUCKINGHAM
Executive Director

SOL BERNSTEIN, M.D.
Medical Director

FOTINE D. O'CONNOR, R.N.
Director, Nursing Services
and Education



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SCHOOL OF PHARMACY

October 26, 1987

William L. Roper, MD
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

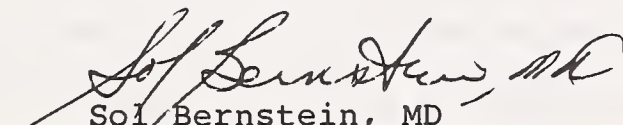
The 1986 Mortality data provided by the Health Care Finance Administration for Medicare patients treated at Los Angeles County-University of Southern California Medical Center have been reviewed by our Medical Director for Utilization Review and presented to our Quality Assurance Committee. The data are accurate and the results indicate that the mortality occurrences are less than in similar reports previously issued by California Medical Review, Inc.

It should be noted that the death rate for these patients is within the predicted range in all categories with the single exception of Sepsis (infection). In this category our rate was 65%, minimally above the predicted upper limit of 62%. A review of the eleven deaths in this category revealed patients which in all cases had multiple and complex underlying conditions such as kidney disease, emphysema, shock, cancer, etc., which were not reversible.

The Medical Center is one of the largest publicly supported hospitals in the nation, is closely affiliated with the University of Southern California School of Medicine, and cares for patients with major acute medical and surgical illnesses. Virtually all medical specialties are provided and our medical services meet or exceed community hospital standards. We believe this data reflects the commitment and the capability of LAC-USC Medical Center to fulfill its mission in the treatment of Medicare patients.

Sincerely,


J.L. Buckingham
Executive Director


Sol Bernstein, MD
Medical Director

JLB:SB:ie
1200 NORTH STATE STREET

LOS ANGELES, CALIFORNIA 90033

PHONE (213) 226-

Robert L. Quist
Administrator

HCA Los Robles Regional
Medical Center

October 22, 1987

William Roper, M.D.
Administrator
Health Care Financing Administration
Washington, D.C. 20201

Mr. Roper:

The hospital-specific mortality data for 1986 sent to us has been reviewed by: the hospital Administrator, Chief of Staff, physician Chairman of the Quality Assurance, Mortality and Utilization Review Committees, the Director of Medical Records and the Coordinator for Quality Assurance. The data has been validated as accurate and reflects patients cared for at Los Robles.

This review revealed that of the 145 deaths reported, 24 occurred after discharge from Los Robles. All deaths reported had been anticipated in view of the patient's condition during their hospital stay.

An intensive review is conducted on every death occurring at Los Robles for appropriateness of medical management and overall care given the individual patient. This is an integral part of our total, ongoing quality assurance program and peer review activities conducted in an effort to meet and exceed quality care standards. This mortality data will be incorporated into that process.

Thank you for the opportunity to verify and respond to this report.

Sincerely,



Robert L. Quist
Administrator

RLQ:jmk

1037 OCT 26 AM 10:19
HCA/EXEC.SEC.

MAD RIVER COMMUNITY HOSPITAL
3800 JAMES ROAD P.O. DRAWER 1115
ARCATA, CALIFORNIA 95521-1115
TELEPHONE: (707) 822-3621

OCTOBER 19, 1987

WILLIAM L. ROPER, M.D.,
HEALTH CARE FINANCING ADMINISTRATION,
HOSPITAL MORTALITY INFORMATION,
P. O. BOX 26684,
BALITMORE, MARYLAND 21207

DEAR DR. ROPER:

THIS LETTER IS IN RESPONSE TO YOUR LETTER OF SEPTEMBER 21, 1987 REGARDING THE RELEASE OF MORTALITY DATA FOR MEDICARE PATIENTS DISCHARGED FROM MAD RIVER COMMUNITY HOSPITAL DURING THE CALENDAR YEAR OF 1986, WHO EXPIRED WITHIN THIRTY DAYS (30) OF THEIR ADMISSION TO MAD RIVER COMMUNITY HOSPITAL.

MAD RIVER COMMUNITY HOSPITAL HAS REVIEWED THE DATA, AND WE HAVE DISCUSSED THE DATA WITH THE H.C.F.A. REPRESENTATIVE.

WE HAVE LEARNED THAT IT IS NOT POSSIBLE FOR THIS DATA TO BE VERIFIED AGAINST THE DATA THAT THE HOSPITAL HAS, DUE TO THE METHODOLOGY OF GATHERING AND DISTRIBUTING THE DATA. THE H.C.F.A. REPRESENTATIVE HAS ASSURED US THAT IT IS NOT POSSIBLE FOR H.C.F.A. TO PROVIDE HOSPITALS WITH A COMPLETE LIST OF NAMES (OR ANY OTHER IDENTIFYING INFORMATION) OF PATIENTS ADMITTED OR DISCHARGED FROM THE HOSPITAL IN 1986. THIS IS TRUE FOR ALL HOSPITALS PROVIDING CARE FOR MEDICARE PATIENTS.

THEY ARE ONLY ABLE TO PROVIDE HOSPITALS WITH THE FIRST SIX LETTERS OF THE LAST NAME OF THE PATIENTS WHO DIED WITHIN THIRTY (30) DAYS OF ADMISSION TO THAT HOSPITAL.

THE LIST PROVIDED TO THIS HOSPITAL BY H.C.F.A. DIFFERS FROM THE HOSPITAL'S RECORDS. OUR RECORDS INDICATE THAT WE HAD 14.04% MORE PATIENTS DISCHARGED THAN THE H.F.C.A. RECORDS INDICATE WE HAD DISCHARGED. WHEN THIS WAS DISCUSSED WITH H.C.F.A.'S REPRESENTATIVE, WE WERE TOLD THAT WE SHOULD BE HAPPY THAT THERE IS SUCH A SMALL DIFFERENCE IN THESE NUMBERS, AS THE DIFFERENCES IN THESE NUMBERS FOR MOST HOSPITALS IS BETWEEN 37% AND 45%.

THE LISTS OF PATIENTS' WHO DID DIE DURING THIS TIME PERIOD ONLY INDICATE THE PATIENT'S DIAGNOSES AT THE TIME OF THE HOSPITAL STAY, AND NOT THE ACTUAL CAUSE OF DEATH. WHILE IT IS TRUE THAT PATIENTS DO DIE OF MEDICAL CAUSES, PATIENTS WHO DIE OUTSIDE OF HOSPITALS ALSO DIE OF NON-MEDICAL CAUSES, SUCH AS AIR/CAR/BOAT/OTHER ACCIDENTS, MURDER, OR SUICIDE. ONE OF THE OUR PATIENTS DIED BY SUICIDE, AND TWO WERE LOST TO FOLLOW UP (LEFT THE AREA), SO THE ACTUAL CAUSE OF THEIR DEATH IS UNKNOWN TO US.

THE LIST OF PATIENTS PROVIDED BY MEDICARE INCLUDES PATIENTS THAT WE HAVE NO RECORD OF AS HAVING BEEN PATIENTS HERE, HAVING DIED, OR HAVING BEEN MEDICARE INSURED.

THE H.C.F.A. REPRESENTATIVE HAS STATED THAT ALL OF THE INFORMATION USED IN THE GATHERING THE DATA, WAS OBTAINED FROM HOSPITAL CLAIMS TO FISCAL INTERMEDIARIES FOR PAYMENT TO THE HOSPITAL, AND FROM THE SOCIAL SECURITY ADMINISTRATION'S RECORDS OF BENEFICIARIES DISCONTINUANCE DUE TO DEATH.

THE NUMBER OF OUR PATIENTS DISCHARGED WAS 0.00674% OF THE NATIONAL NUMBER OF MEDICARE PATIENTS OF 6,700,000. THE DEATH RATE FOR OUR IN-PATIENTS WAS 10.68%. THIS DOES NOT INCLUDE PATIENTS WHO DIED AFTER THEIR DISCHARGE FROM THIS HOSPITAL.

IT IS IMPOSSIBLE TO ACCURATELY INFER STATISTICAL SIGNIFICANCE TO THIS DATA.

SINCERELY,

A handwritten signature in cursive script, appearing to read "Michael J. Young".

MICHAEL J. YOUNG, ADMINISTRATOR

MJY:ks

10HCFAB7



Marin General Hospital

October 26, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
PO Box 26684
Baltimore, MD 21207

Provider No.: 050360

Dear Dr. Roper:

Marin General Hospital would like to take this opportunity to respond to HCFA's recent release of hospital specific mortality data for 1986.

Even though Marin General Hospital data falls within the Predicted Mortality Range (PMR) we feel that it oversimplifies the issue of mortality as it relates to quality of care. Beyond that, we have some serious concerns about the possible misuse and misinterpretation of the data.

After reviewing the data, we are left with some troubling questions about the assumptions and credibility of the methodology as well as the definitions and categorization of the data. For example, it is difficult to understand how to interpret a "predicted range" of 0-92% as seen in our Gyn category. Also, in the category of "severe trauma", it is misleading as it includes such diagnoses as fractured hips/femurs which most people typically consider to be an orthopedic category.

The recent data includes patients who expired after discharge but only if they expired within 30 days from the date of the admission. The patient's death might be totally unrelated to the hospitalization but is nonetheless summarized with our facilities statistics. It is therefore difficult to make any correlation between those patients who died while at Marin General Hospital or those occurring after discharge. In previous releases the data was summarized differently. For example, it included all patients who expired during their hospitalization, regardless of the date of admission or category of diagnoses. Marin General Hospital has a comprehensive Quality Assurance Program which routinely reviews all cases of mortality.

Further, the recent release, as with the previous releases does not take into account how ill the patient was upon admission, nor the severity or stage of the illness. Certain hospitals treat the more seriously ill patients for a geographic area. Because Marin General Hospital traditionally has treated a disproportionate number of these patients, we are more concerned about the interpretation of the mortality data even though our data falls within the predicted ranges.

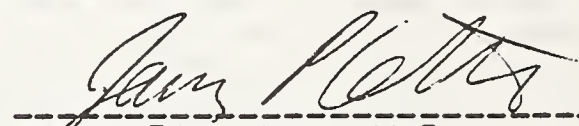
In summary, Marin General Hospital has concerns that, in its current

format, the HCFA Mortality Data for 1986 has the potential for misinterpretation and misuse. The AHA and other organizations are currently looking at other methods for evaluating hospital quality and we look forward to the results of those efforts.

Sincerely,



Mark Lambert, M.D.
Chairman of Care Review Committee



James Fletcher, M.D.
Chief of Medical Staff



Henry J. Buhrmann
President



Mark Twain District Hospital

MEDICARE PROVIDER NUMBER 05-0366

October 26, 1987

William L. Roper, M.D.
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for this opportunity to respond to HCFA's current release of data on hospital mortality rates for Medicare patients treated during 1986.

We have reviewed the data, and each death in the category in which our death rate was higher than the predicted range, and would like to issue the following statement:

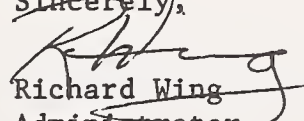
The 1986 Mortality Rates for Medicare patients treated at Mark Twain District Hospital are below or within the predicted range in all but one Diagnostic Category. In this category, "Cerebrovascular Accidents", which includes acute strokes due to cerebral hemorrhage, embolism, or other causes, our rate is higher than predicted based on factors considered by HCFA in developing these statistics.

After review of these cases, we have determined that those patients who died received excellent care, but did not survive because of the severity of their illness. There is no indication that severity of illness was a factor in the determination of mortality rates, although other information such as patient's age, sex, other illnesses, and previous hospital admissions was considered.

On an ongoing basis, our Medical Staff Quality Assurance Committee reviews the care provided to all patients, and will continue to do so. We recognize that mortality rates do not necessarily reflect the quality of care and welcome any questions the public may have about the care provided at our facility.

Thank you for the opportunity to present this response. If you or anyone receiving this material have questions, please contact me.

Sincerely,


Richard Wing
Administrator

RW/lr



**MARTIN LUTHER HOSPITAL
MEDICAL CENTER**

1830 West Romneya Drive
Post Office Box 3304
Anaheim, California 92803
(714) 491-5200

GEORGE H. MACK *president & executive director*

October 27, 1987

Health Care Financing Committee
Health Mortality Data
6300 Security Blvd.
Meadows East Bldg.
Room 2D2
Baltimore, MD 21207

Dear Sir:

Enclosed is Martin Luther Hospital's response to the 1986 HCPA mortality statistics.

The response was originally sent to CMRI by mistake. Despite the unintentional delay I would hope that MLHMC's response to the mortality statistics will be made available for public review.

Sincerely,

George H. Mack
President & Executive Director

jf

30.022



**MARTIN LUTHER HOSPITAL
MEDICAL CENTER**

1830 West Romneya Drive
Post Office Box 3304
Anaheim, California 92803
(714) 491-5200

GEORGE H. MACK *president & executive director*

October 27, 1987

Health Care Financing Committee
Health Mortality Data
6300 Security Blvd.
Meadows East Bldg.
Room 2D2
Baltimore, MD 21207

Dear Sir:

The following is a comment for the record regarding HCFA's current release of data on mortality statistics for Medi-Cal patients treated at Martin Luther Hospital Medical Center in 1986.

Martin Luther Hospital is well within the accepted parameters for statewide averages in all diagnostic categories with the exception of cancer related deaths. The hospital exceeded the statewide average by one (1) percent.

It should be noted that Martin Luther Hospital has a licensed oncology unit. In review of the reported cancer related deaths, all patients were in the advanced stages of their disease process with metastasis to several sites and death anticipated.

For the records, three deaths reported by HCFA as occurring post discharge did, in fact, occur during hospitalization.

As with prior HCFA data all significant findings in review will be shared with the Medical Staff so that they may be able to respond to any questions by the public or their patients.

Thank you for the opportunity to present this response. If you have any questions, please contact me at (714) 491-5678.

Sincerely,

George H. Mack
President & Executive Director

jf

cc: Jon D. Gilwee HCSC
W. Kenneth Halliday, M.D., Chief of Staff

30.004

CA 277.1



MARTIN LUTHER KING, JR. GENERAL HOSPITAL

KING/DREW MEDICAL CENTER

CHARLES R. DREW POSTGRADUATE MEDICAL SCHOOL

12021 South Wilmington Avenue • Los Angeles, California 90059 • (213) 603-4321

WILLIAM A. DELGARDO
ADMINISTRATOR

LEONARD A. TUREAUD, M.D.
MEDICAL DIRECTOR

EMMA DELL FOLEY, R.N.
DIRECTOR OF NURSING

October 16, 1987

William L. Roper, M.D., Administrator
Department of Health & Human Services
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

We received your letter dated September 21, 1987, which transmitted all short term acute Medicare patients who died within thirty days of their last admission of 1986 to our hospital.

Based on a thorough review of the data, we have decided not to submit comments to the report. As part of our ongoing review, we used your data as comparison to our data and found no discrepancies.

We will continue to perform ongoing monitoring of our patients to achieve high quality patient care.

Sincerely,

James G. Haughton, M.D., M.P.H.
Medical Director

cc: William A. Delgado
Administrator

Carl Williams
Assistant Director, Health Services, Hospitals

 AMI Tarzana Regional Medical Center

#050601

October 23, 1987

The data used by HCFA (Health Care Financing Administration) indicates that a total of 151 Medicare patients admitted to AMI Tarzana Regional Medical Center died within 30 days of admission. Of these, 126 died while still a patient of the hospital, while 25 died after discharge. Our own records indicate that 2494 Medicare admissions occurred in 1986. Six percent died, including those within 30 days after admission, and 4% died during hospitalization.

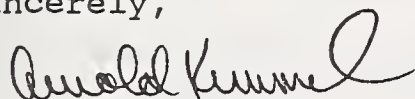
It is imperative to understand that the diagnoses selected through this process are on Medicare coding guidelines based on principal diagnosis. The definition of a principal diagnosis is that which is the primary reason for the admission into the hospital. This method does not take into consideration any major co-morbid conditions which may have a significant effect on the outcome of the hospitalization and the patient discharge status.

Although we are well within the predicted range, it is important to emphasize that our hospital specializes in an oncology unit and a diabetes treatment center.

We have a hospital-wide Quality Assurance program which conducts on-going death chart review, as well as other chart review, by our Medical Staff.

Upon investigation of the statistics given to us by HCFA, it was noted that all patients were confirmed as being treated by our hospital. Tarzana Regional Medical Center has reviewed all deaths and divided the categories of low risk and those dying outside the hospital for in-depth review. Our Quality Assurance Committee reviewed the ten cases that were coded into the "low risk" category, but upon investigation of these records, it was found that seven, due to the Medicare coding guidelines, did not reveal significant co-morbid conditions which were present, one patient died of old age deterioration, one patient had an error in the HCFA coding category; should have been high risk; and finally there were two possible principle diagnoses of a patient; the high risk condition should have been coded first.

Sincerely,



Arnold Kimmel
Executive Director



Office of Administration



October 26, 1987

Healthcare Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
Baltimore, Maryland 21207

Dear Sir:

Thank you for the opportunity to respond to HCFA's release of data on hospital mortality rates reflecting discharges from 1986.

Our comments will be restricted to the Pulmonary Disease category, in which the mortality rate was 2 % above the range of predicted mortality rates.

Upon verification of this data, it was noted that one patient listed was never a patient at this facility. It appears to be an error as the dates of admission, discharge, age, and HIC number are exactly the same as the patient listed directly above. We have indicated this patient on the attached HCFA mortality list.

Although we question the relationship between mortality and quality of care provided, we will attempt to provide information concerning the nature of the patients the co-morbidities and the severity of illness which we believe has more effect on mortality.

The cases in this category have been thoroughly reviewed by members of the hospital Quality Assessment Committee. It was determined after review that:

- o of the 52 patients who expired within 30 days of admission, 16 patients (31 %) expired after being discharged from the hospital alive. 12 of those 16 (75 %) were transferred directly to a skilled nursing facility.
- o Of the 52 patients who expired, 37 (71 %) were as a result of following the patient and/or family's wishes with respect to no "heroic" or "extraordinary" measures because they were determined to be in the final stages of their illness. 8 of the 12 patients who expired after being transferred to a nursing facility were also in this category.
- o 96 % of the patients had multiple system disease processes which compromised their condition, including associated heart failure and

An American Medical International, Inc. Health Care Center

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

chronic heart disease (47%), renal failure/pre-renal azotemia (15%) diabetes (17%), cancer (9%), septicemia or septic shock (15%), as well as stroke and severe metabolic and electrolyte disorders. Many patients had 3 or more of these conditions simultaneously. (One patient's cause of death was due to heart attack, although the reason for admission was for treatment of a pulmonary condition).

- o For one patient who expired after leaving the hospital, the cause of death was listed as due to cardiac problems and was not due to the patient's pulmonary condition.

The above supports our contention that the mortality rate in this category is higher because of the condition of the patients treated and not the treatment itself.

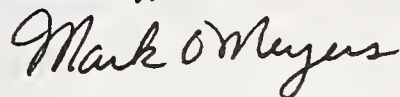
The following information should also be taken into account when reviewing any mortality data for the Medical Center of Garden Grove.

- The hospital is in close proximity to several nursing homes. Approximately 93% of pulmonary deaths are admitted from a skilled nursing facility or through the hospital emergency room.
- As part of the hospital's ongoing Quality Assessment Program, all unexpected deaths are screened and reviewed by the relevant service committee of the medical staff.

The Medical Center of Garden Grove supports the principle of communicating appropriate and meaningful evaluations regarding hospital services to the community and welcomes the opportunity to discuss factors that relate to the mortality data that is reported for this hospital.

Thank you for the opportunity to respond.

Sincerely,



Mark A. Meyers
Executive Director

MAM/cd/3.L58

MEMORIAL HOSPITAL AT EXETER

215 CRESPI AVENUE • EXETER, CALIFORNIA 93221 • (209) 592-2151

October 26, 1987

William L. Roper, M.D., Administrator
Department of Health and Human Services
Washington, D.C. 20201

RE: Mortality Information

Medicare Provider No. 50286

Dear Doctor Roper:

Please note two errors in the mortality information:

1. Patient [REDACTED] was not a patient in our hospital.
2. Patient [REDACTED] was assigned a principal diagnosis of 507.0; 410.4 was the third diagnosis.

Memorial Hospital at Exeter has a distinct part skilled nursing facility, comprising nearly 30% of the licensed beds. Memorial Hospital has derived 50% of admissions in the acute hospital from the age group of 65 years and older. The combining of these two factors suggest that mortality rates may be outside the range of predicted mortality rates. This occurs in only one major diagnostic category, cerebrovascular accidents.

The model developed by the Health Care Financing Administration assumes all patients to be "equal" upon admission, such as in terms of general health status, stage of the patient's illness, the patient's psychological condition, and family support. The model may reflect the relationship between some patient characteristics and death, but it does not reliably predict hospital mortality rates.

Thank you for the opportunity to comment.

Sincerely,



Sally Brewer
Administrator

SB:sel

Response to HCFA Release of Mortality Data

Memorial Medical Center of Long Beach

The 998-bed Memorial Medical Center of Long Beach continues to enjoy a national reputation as one of the country's major tertiary institutions.

Centers of excellence based at Memorial, to which thousands of high risk patients are transferred each year, include the state's largest high risk maternal transfer program, California's second-largest neonatal intensive care unit, a national referral respiratory program, the country's oldest baromedicine unit, and a nationally-lauded circulatory program.

Also, as one of only five Level I trauma centers in Los Angeles County, Memorial receives the most severe illness and injury cases occurring in southern Los Angeles, and northern Orange counties.

Due to Memorial's leadership position in these, and many, many other areas of high risk medical care, the institution maintains a level of severity in its case-mix that is unsurpassed in Southern California. Currently, Memorial maintains high-risk transfer relationships with more than 100 Southern California hospitals not equipped or staffed to deliver those specialized services.

While Memorial applauds HCFA's efforts to establish baseline criteria to define "quality of care," we feel strongly that these statistics -- in their current form -- require a context and perspective in which to truly understand them. Memorial has a number of representatives that would be more than happy to help explain this process more clearly and to discuss the various statistical elements that go into the calculation of these figures.

If you would like to contact a Memorial representative in regard to these statistics, please call Doug Stokke at (213) 595-2116.

MEMORIAL
HOSPITALS ASSOCIATION
P.O. Box 942/Modesto, CA 95353
(209) 526-4500

MEMORIAL MEDICAL CENTER

Thank you for the opportunity to review the selected mortality information which HCFA plans to release in December, 1987, for Memorial Medical Center, 050557.

There are several corrections that need to be made to the data for Memorial Medical Center, 050557. These include the deletion of one (1) patient that was admitted at Memorial Hospital Ceres, four (4) cases in which the patient's previous admissions have been combined with subsequent admissions in which the patients died, and nine (9) cases in which the HCFA data indicates the patients died subsequent to dismissal from Memorial Medical Center while in reality the patients died while hospitalized. The cases are detailed on the attached page.

Memorial Medical Center is a 170 bed community owned, non-profit general acute care facility located in Modesto, California. The Memorial Medical Center and Memorial Hospital Ceres are operated by the Memorial Hospitals Association. There are 138 medical/surgical acute care beds, 5 coronary care beds, 5 intensive care beds, 12 perinatal beds and 10 pediatric beds.

Memorial Medical Center is the only American College of Surgeons approved cancer treatment program in Stanislaus County. The facility provides radiation therapy services in addition to maintaining a dedicated nursing unit for oncology patients. The Memorial Medical Center is the only facility providing inpatient acute and chronic dialysis treatments. The presence of these services result in the admission of patients with more severe illnesses to this facility.

The Quality Assurance Program at Memorial Medical Center, 050557, is a comprehensive on-going program that reviews and evaluates the patient care provided by medical Staff members and hospital employees. Its goal is twofold; to resolve problems and to identify opportunities to further improve patient care practices and hospital systems.

Mortality is but one of many factors that are utilized to focus peer review activities. In addition to patients developing complications (morbidity), the Quality Assurance Program utilizes generic screens (patient care related events such as an unscheduled return to surgery or an unplanned transfer to the intensive care unit following admission, etc.), specific screens (additional patient care related events pertinent to the practice of the Medical Staff or hospital department post-operative admission following outpatient surgery, etc.) the Joint Commission defined the Medical Staff review functions (review of blood usage, hospital acquired infections, etc.), and monitors addressing the quality and appropriateness of patient care services. Criteria adopted by the Medical Staff are utilized by non-physicians (nurses and medical record professionals) to screen cases each month. Those cases not meeting the criteria are reviewed by physicians. Questions resulting from physician review are forwarded to the practitioners involved in the patient's

care. Responses are reviewed by the appropriate Medical Staff department or committee. Actions which are taken as a result of the review process are monitored in order to determine their effectiveness. Additionally, findings are monitored by the Quality Assurance committee in order to identify any trends. Monthly the Board of Directors of Memorial Hospitals Association receives a report regarding the Quality Assurance activities that have been delegated to the Medical Staff.

The Memorial Hospitals Association Board of Directors, Medical Staff and hospital staff are committed to providing quality services to it patients. It does not feel that quality judgements can be made based upon one factor such as a predicted death rate. Quality judgement can only be made on the basis of the review of individual medical records.

Diane Hasler
Vice President/Administration
Memorial Hospitals Association
P. O. Box 942
Modesto, CA 95353

Memorial Medical Center Modesto 050557

Corrections:

Delete:

Patient at Memorial Hospital Ceres 050154

Incorrect admission and dismissal dates; patient died in hospital during subsequent admission.

[REDACTED]	<u>07/08/86</u>	<u>07/11/86</u>	<u>07/11/86</u>
[REDACTED]	<u>04/15/86</u>	<u>04/23/86</u>	<u>04/23/86</u>
[REDACTED]	<u>08/15/86</u>	<u>08/28/86</u>	<u>08/28/86</u>
[REDACTED]	<u>01/04/87</u>	<u>01/10/87</u>	<u>01/10/87-</u>

delete (?) last
inpatient admission
in 1987

Incorrect dismissal date; patient died during hospitalization

[REDACTED]	05/30/86	06/17/86	<u>06/17/86</u>
[REDACTED]	10/22/86	10/28/86	<u>10/28/86</u>
[REDACTED]	11/18/86	11/28//86	<u>11/28/86</u>
[REDACTED]	11/21/86	11/21/86	<u>11/21/86</u>
[REDACTED]	11/18/86	11/28/86	<u>11/28/86</u>
[REDACTED]	01/06/86	01/22/86	<u>01/22/86</u>
[REDACTED]	05/01/86	05/03/86	<u>05/03/86</u>
[REDACTED]	11/09/86	11/25/86	<u>11/25/86</u>
[REDACTED]	11/25/86	11/28/86	<u>11/28/86</u>



Memorial Hospital of Gardena

1145 West Redondo Beach Boulevard, Gardena, California 90247 • 213/532-4200

October 16, 1987

William-L. Roper, M.D.
Department of Health and Human Services
The Administrator
Washington, D.C. 20201

Re: MORTALITY INFORMATION - MEDICARE PROVIDER NUMBER 050468

Dear Dr. Roper:

Thank you for affording us the opportunity to respond to HCFA mortality information prior to the information being made public.

Memorial Hospital of Gardena is a 200 bed acute care hospital. The case mix includes many patients with major medical and surgical illnesses. We provide a wide range of services including inpatient and outpatient surgery, Intensive Care Unit, Coronary Care Unit, Emergency Room, Radiology, Laboratory, Pharmacy and Home Health.

The Hospital cares for a high percentage of Medicare patients, 45-55%, with an average age of 78 years old.

Since receiving the mortality statistics they have been analyzed by several key people including the Director of Medical Records who verified the information which, except for minor exceptions is correct.

The method the hospital used to check HCFA data was to have the medical records manager review the charts for accuracy. The primary physician was identified for each of the patients the HCFA report states died within 30 days following discharge. The physician offices were contacted to verify the date of death, however, the only information available was the confirmation by the office personnel that death did occur. None of the physician's offices that were contacted were able to produce the actual date of death. The verifying records were in off-site storage in every case.

Information pertinent to this report is as follows:

- o All patients listed in the HCFA report did die during hospitalization or some time following discharge.
- o Of the 30 patients listed as dying within 30 days following discharge, 4 (13%) actually did die in the hospital, leaving 26 dying after being discharged.
- o There is no way to verify the remaining 26 patients that died within 30 days of discharge except to call their families. Of course, that is not an option for obvious sensitivity reasons.

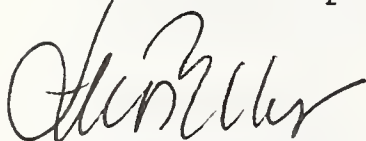
We are very pleased to see that all of our mortality rates fell within the predicted range. This suggests that Memorial Hospital of Gardena's mortality rate in all diagnostic categories studied, was comparable to 95% of the hospitals nationwide who treat patients in similar circumstances.

The Medical Staff at Memorial Hospital of Gardena conducts an intensive review of the medical record of every patient who expires at this facility, regarding medical management and overall care. Mortality review is an on-going process of the Quality Assurance program, and peer review activities are an integral part of the monitoring of the healthcare delivery system at this hospital.

If the mortality information or these comments generate any questions, please contact me, Seth Ellis, Executive Director, at (213) 532-4200.

Sincerely,

Memorial Hospital of Gardena



Seth Ellis
Executive Director



Robert Goyette, M.D.
Chief of Staff

SE/lc

MEMORIAL
HOSPITALS ASSOCIATION
P.O. Box 942/Modesto, CA 95353
(209) 526-4500

MEMORIAL HOSPITALS CERES

Thank you for the opportunity to review the selected mortality information for Memorial Hospital Ceres, 050154, which HCFA will release in December, 1987.

There is one (1) correction which needs to be made to the data released regarding Memorial Hospital Ceres, 050154. One death, [REDACTED] 05/11/86 05/15/86 05/16/86 428 3491 was included in the data for Memorial Medical Center, 050557; the admission was at Memorial Hospital Ceres, 050154.

Memorial Hospital Ceres is a general, acute, non-profit community owned hospital with 24 medical/surgical beds, 3 intensive care beds, 3 coronary care beds, 21 acute psychiatric beds, 21 chemical dependency beds and 48 skilled nursing beds. The community owned Memorial Hospitals Association has another acute care facility, Memorial Medical Center in Modesto, California.

The Quality Assurance Program at Memorial Hospital Ceres, 050154, is a comprehensive on-going program that reviews and evaluates the patient care provided by Medical Staff members and hospital employees. Its goal is twofold; to resolve problems and to identify opportunities to further improve patient care practices and hospital systems.

Mortality is but one of many factors that are utilized to focus peer review activities. In addition to patients experiencing complications, the Quality Assurance Program utilizes generic screens (patient care related events such as an unscheduled return to surgery or an unplanned transfer to the intensive care unit, etc.), specific screens (additional patient care related events pertinent to the practice of the particular Medical Staff or hospital department such as postoperative admission following outpatient surgery, etc.), the Joint Commission defined Medical staff review functions (review of blood usage, hospital acquired infections, etc.), and monitors addressing the quality and appropriateness of patient care services. Criteria adopted by the Medical Staff are utilized by non-physicians (nurses and medical record professionals) to screen cases each month. Those cases not meeting the criteria are reviewed by physicians. Questions resulting from physician review are forwarded to the practitioners involved in the patient's care. The responses are reviewed by the appropriate Medical Staff department or committee. Actions which are taken as a result of the review process are monitored in order to determine their effectiveness. Additionally, findings are monitored by the Quality Assurance Committee in order to identify any trends. Monthly the Quality Assurance Review activities are reported to the Board of Directors of Memorial Hospitals Association.

The Memorial Hospitals Association Board of Directors, Medical Staff and hospital staff are committed to providing quality services to its patients. It does not feel that quality judgements can be made based upon one factor such as a predicted death rate. Quality judgements can only be made on the basis of the review of individual medical records.

Eleven of the patients included in the mortality data died following dismissal from Memorial Hospital Ceres. Sixty-four percent of these patients were actually transferred to a lower level of care, the skilled nursing facility at Memorial Hospital Ceres (five) and two convalescent hospitals (two). Another patient went to a Veterans Administration hospital while one patient signed himself out against medical advice from the chemical dependency program. Two of the patients returned to their homes.

When patients have reached maximal hospital benefits, transfer to a more suitable level of alternative care may be desirable. Hospital based skilled nursing facilities have been found to care for patients of higher acuity than free standing skilled nursing facilities. This holds true for the skilled nursing facility based at Memorial Hospital Ceres. The nursing hours per patient day on the skilled nursing facility is 4.6. The nursing hours per patient day are 5.6 in the acute facility. The hours of nursing care in a skilled nursing facility required by California statute are 3.0 per patient day.

Sincerely,



Diane Hasler
Vice President/Administration
Memorial Hospitals Association
P. O. Box 942
Modesto, CA 95353

MEMORIAL HOSPITAL
SAN LEANDRO

TO: William L. Roper, M.D.
Administrator

FROM: Catherine Pelley
Executive Director 

DATE: October 27, 1987

RE: HCFA Mortality Data

Comments regarding the Mortality Data for Memorial Hospital - San Leandro is attached.

If you have any questions, please do not hesitate to call.

2800 Benedict Drive, San Leandro, CA 94577 (415) 357-8300

COMMENTS ON THE HCFA MORTALITY DATA

MEMORIAL HOSPITAL - SAN LEANDRO

SAN LEANDRO, CALIFORNIA

Thank you for the opportunity to comment on the mortality statistics for the period of January 1 - December 31, 1986.

By way of background, Memorial Hospital - San Leandro is a 142 bed general acute care hospital providing medical and surgical services to residents of San Leandro and surrounding communities in Alameda County. The hospital treats a high percentage of Medicare patients, a majority of whom are more than 80 years old.

The HCFA data has been analyzed by Memorial Hospital's Executive Director, Chief of Staff, Director of Quality Care Review and Assistant Administrator.

We have found HCFA's data base to be correct, with all but one of 16 diagnostic categories falling within the predicted range. The one exception was the broad diagnostic category of sepsis, a medical condition generally demonstrated in elderly, chronically-ill patients. Patients admitted to Memorial Hospital with this diagnosis demonstrated a high degree of debilitation and illness on admission for acute care. The average age of death for patients in this category was 80 years old. A majority of these patients died within 72 hours of admission.

The medical staff at Memorial Hospital - San Leandro conducts an intensive review of the medical record of every patient who expires at this hospital. This review explores both medical management and overall quality care and is an ongoing part of the Quality Assurance Committee and peer review activities. We believe that our review process provides a continuous feedback mechanism that allows us to meet and exceed quality of care standards.

Although this mortality data provides limited information that is likely to be mistakenly used as a measure for quality of care, we applaud these initial steps at providing information to the consumer that will help them to become more active and informed in their health care decisions.

If you have additional information, please contact Patricia D. Atallah, R.N., Assistant Administrator at (415) 357-8300.

MERCED COMMUNITY MEDICAL CENTER

October 21, 1987

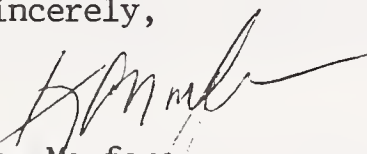
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Sirs:

We have reviewed the Medicare mortality statistics you provided us for Merced Community Medical Center and have no problem with them. In fact, we are encouraged by this validation of the fine quality of care we give. In our geographic area, we tend to see the sickest patients and those most compromised; we find ourselves on the low end to median of your statistical bands in all but one category. In that one instance, the sample size was only two patients; with small sample sizes, the statistics can fluctuate greatly as more individuals are added. A review of those cases did not point out any problems in patient treatment.

Thank you for the opportunity to review this data.

Sincerely,


Ken Monfore
Administrator

KM/JM:paw

Mercy Hospital

October 23, 1987

William L. Roper, M.D.
Administrator
Department of Health & Human Services
Washington, DC 20201

Re: Medicare Provider #05-0295

Dear Dr. Roper:

Thank you for the opportunity to utilize and comment on the selected Medicare mortality data for Mercy Hospital for the year 1986.

Mercy Hospital is a 276-bed community hospital offering a full range of medical and surgical services, including intensive care and a 50-bed skilled nursing facility. As one of the health care institutions sponsored by the Sisters of Mercy, Mercy Hospital and its associated programs and services exist to enhance the quality of life and to provide for the unique needs of the Bakersfield community.

After carefully reviewing this data, Mercy Hospital is pleased to note that our actual experience in all cases falls within the range of predicted mortality rates established specifically for Mercy Hospital by the Health Care Financing Administration (HCFA). While this data does not include all patients of Mercy Hospital, it does give us data on an important segment of the community.

Recognizing that the hospital's data fell in the predicted range in all categories, we chose to further analyze the severe acute heart disease category. Our evaluation of those patients who died in this category revealed the following:

- > The range of predicted mortality rates for patients with severe acute heart disease at Mercy Hospital is 30-52%. Our experience is 52%.
- > Four of these patients (9%) were transferred to us in critical condition from other acute care hospitals.
- > Eleven patients (24%) experienced a cardiac and/or respiratory arrest prior to admission.

P.O. Box 119
2215 Truxtun Avenue
Bakersfield, Ca. 93302
(805) 327-3371

William L. Roper, M.D.

October 23, 1987

Page 2

- > Twenty-four patients (52%) were given a "no resuscitation" status by the physician upon request of the patient and/or family.
- > Thirty-eight patients (83%) were admitted through the hospital's Emergency Department, indicating the severe nature of their illness.
- > The majority of these patients were admitted with an advanced disease process. Despite aggressive measures to stabilize the disease process, death occurred.

Mercy Hospital treated a total of 4,778 Medicare patients in 1986, with an overall death rate of 7.8%, which compares favorably to the HCFA data released.

Consistent with the ongoing quality assurance program of Mercy Hospital and its medical staff, all patient deaths are routinely reviewed. This process assists us in improving the services provided.

Again, thank you for this opportunity to respond to our data.

Sincerely,


Bernard J. Herman
President


Stephen J. Helvie, M.D.
Chief of Staff

BJH:jmh



**Mercy
Hospital
and
Medical
Center**

Serving the Community since 1890
619/294-8111
4077 Fifth Avenue
San Diego, California
92103-2180

October 22, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Washington, D.C.

Dear Dr. Roper:

Thank you for your letter of 9/21/87 outlining the mechanism for publishing and responding to the 1986 Medicare Mortality Statistics. The following are comments from Mercy Hospital and Medical Center in San Diego:

In all diagnostic categories, Mercy Hospital's actual mortality rate was either less than, or within, the range of predicted mortality rates. In the two diagnostic categories for which the predicted range of mortality rates began with 0% and ranged upward, Mercy Hospital had zero mortalities. When all diagnostic categories are combined, Mercy Hospital's actual mortality rate was within 2% of the lowest predicted percentage of mortalities. In 12 of the 16 diagnostic categories Mercy Hospital's actual mortality rate was either less than the bottom of the range, or in the lower half of the predicted range of mortality rates.

We caution those reviewing the mortality statistics not to draw conclusions about the quality of care in particular hospitals based on the data released by CMRI.

Mercy Hospital and Medical Center Medicare Provider # - 05-0077B.

Sincerely,


Susan Maddox

Vice President, Consumer Services



October 21, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Health Care Consumer:

Thank you for the opportunity to provide input on the mortality statistics for the period of January through December, 1986.

The hospital specific mortality data reported by HCFA has been carefully reviewed by: the hospital administrator, President of the Medical Staff, Physician Chairman of the Utilization Review Committee and the hospital Quality Assurance Department. We have validated that the data is generally accurate, and we have no specific comments to offer with respect to the report.

The Medical Staff at Mercy Hospital of Folsom conducts an intensive review of the medical record of every patient who expires at this facility regarding medical management and overall care. Mortality review is an on-going process of the Quality Assurance Program and peer review activities are an integral part of the monitoring of the health care delivery system at this hospital.

Mercy Hospital of Folsom is a 39 bed acute care facility whose casemix includes many patients with major acute and chronic medical and surgical illnesses.

The Medical Staff of Mercy Hospital of Folsom, as has been their practice, will continue to review all mortality cases for quality and appropriateness of care rendered to the individual patient. Trending analysis from these reviews is a constant endeavor to assist in identifying opportunities to improve care.

Sincerely,



Rod Eason,
Administrator



MERCY HOSPITAL

2740 M STREET • MERCED, CALIFORNIA 95340-2880 • (209) 384-6444

October 27, 1987

Mr. Harvey Brook
Health Standards and Quality Bureau
Health Care Financing Administration
Room 2-D-2
Meadows East Building
6300 Security Boulevard
Baltimore, MD 21207

RE: Mercy Hospital 05-0117

Dear Mr. Brook:

Thank you for giving us the opportunity to provide you with input on the mortality statistics for the period of October 1, 1984 through September 30, 1986. Our hospital medical staff committees monitor every death in our facility on an ongoing basis. We believe that our monitoring system provides us with a continuous feedback mechanism in an effort to continue to meet and exceed quality care standards.

It is to be noted that in all of the diagnostic categories, Mercy Hospital's actual mortality rate falls either below or just outside the low range of the predicted mortality rate. We would also like to point out to individuals reviewing this data to keep in mind that these statistics do not reflect severity of illness, the impact of multiple diagnoses, complications, comorbidities, and age of any one patient.

Again, thank you for the opportunity to present this information.

Sincerely,

Dennis W. Marshall
President/CEO

DWM/jle/MSS5



October 8, 1987

William L. Roper, M.D.
Administrator
Department of Health & Human Services
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

This letter is in response to HCFA's data release for mortality of MediCare patient's treated at Mercy San Juan Hospital (provider #050516) in 1986.

The report has been reviewed and analyzed by Administration, our Quality Assurance and Utilization Review Physicians.

We have validated that, with minor exceptions, the data is accurate. The data shows our overall death rate for this period of time was at the low end of the range of predicted mortality rates. In all categories we were within the predicted range of mortality rates.

All deaths in this hospital are included in the ongoing review by our Medical Staff Quality Assurance, Utilization and Peer Review Programs.

Sincerely,

Gregg Schnepple
Chief Executive Officer
Mercy San Juan Hospital

GS:11



Frank Puglisi, Jr.
Executive Director
Merrithew Memorial Hospital and Clinics
2500 Alhambra Avenue
Martinez, CA 94553

October 19, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Bx 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Merrithew Memorial Hospital has carefully reviewed the Health Care Financing Administration's (HCFA) mortality information about Medicare patients treated in our facility in 1986. According to this information, the mortality rate for Medicare patients at Merrithew fell within the predicted range of mortality rates in all of the sixteen Major Diagnostic Categories (MDC's) presented. The predicted percentage range of expected deaths for Merrithew was determined by HCFA.

There are two MDC's, however, where the mortality rate was at the upper end of the predicted mortality range. These categories were "severe acute heart disease" and "sepsis." The mortality rates for these categories were calculated based upon a combined total of fifteen cases. This small sample size may be misleading when analyzing percentage rates because one or two cases out of a small sample may significantly alter a percentage rate, whereas one or two cases out of a large sample may have little or no effect on a percentage rate.

The mortality statistics show that there were ten deaths within the MDC of "severe acute heart disease." More than half of these deaths involved patients who were emergency admissions to the hospital. They were in critical condition upon arrival and required care in the Intensive Care Unit. In addition, the majority of the patients suffered complications from their initial health problem and/or had other chronic problems such as diabetes or hypertension.



Contra Costa County

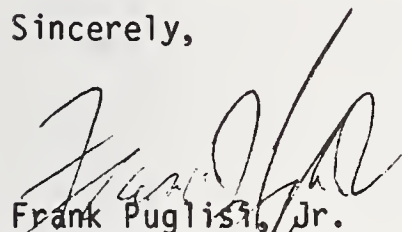
In addition, three of the ten deaths within the MDC of "severe acute heart disease" occurred outside of the patients' hospital stay at Merrithew. These deaths appear in the statistics because HCFA's mortality rates include those deaths which occur thirty (30) days after admission, regardless of how long the patient stayed in the hospital. For instance, if a patient was discharged after seven days of hospitalization and died twenty days later at home, this death would be included in the discharging hospital's mortality rate, even if the death was unrelated to the patient's condition while in the hospital.

The second MDC where the mortality rate was at the upper end of the predicted range was "sepsis." Within the small sample of five cases in this category, the majority of the patients were emergency admissions from convalescent hospitals. All of the patients arrived in a comatose state and were in shock due to an overwhelming infection. All of the patients had other serious medical problems in addition to the infection and 40% of the five patient's had previously established "no resuscitation" instructions.

Our review of the fifteen cases in categories of "severe acute heart disease" and "sepsis" confirms that the patients in these categories had consistently poor health and critical acute illnesses, which made their chances for survival very poor. In all of the remaining categories, Merrithew's mortality rates were well within HCFA's predicted range.

I appreciate the opportunity to respond to the mortality information presented by HCFA.

Sincerely,



Frank Puglisi, Jr.
Executive Director,
Hospital and Clinics

FP/dmb



METHODIST HOSPITAL OF SOUTHERN CALIFORNIA

300 WEST HUNTINGTON DRIVE • ARCADIA, CALIFORNIA 91006 • (818) 445-4441

FREDERICK C. MEYER
PRESIDENT

October 27, 1987

William L. Roper, M.D. Administrator
Department of Health and Human Services
Health Care Financing Administration
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Re: Medicare Provider #05-0238

Methodist Hospital welcomes the opportunity to discuss issues that may be related to the quality of care delivered to patients. We received the mortality data issued by the Health Care Financing Administration, and although a thirty (30) day comment period is probably insufficient time to thoroughly scrutinize the data, we have examined the data with some detail.

We are pleased to report that Methodist Hospital was within the predicted mortality range, set forth by the Health Care Financing Administration, in every category, and in several categories, fell into the low "norm ranges" for predicted death outcomes. We feel the public, however, should know HCFA ranges are "predicted" and that the statistical model used has not been validated by determining actual death rates, nor do these statistics reflect the quality of health care delivered.

Unfortunately, some of our primary concerns regarding this data which we have related in previous responses has not been remedied. The severity of illness factor is still not a primary feature of the data especially in concomitant diagnoses. Secondly, the patient's general health prior to and at the time of admission, as well as the patient's mode of transportation to the hospital, are essential determinants in the patient's prognosis; but these too, are not considered. Additionally, we believe paramedic assistance and the type of services the hospital renders will influence mortality rates. Often it is the hospital that offers the most specialized and comprehensive services that receives the sickest, the most severe, and the most likely patients to succumb to illness.

The Health Care Financing Administration has also added a new dimension to its data by including all patients that died thirty (30) days after admission whether these patients died in the Hospital or not. In one diagnostic category, 44% of our patients did not die while in our hospital. This means some deaths may not be related to a particular hospitalization or to the identified diagnosis as presented in the data. Patients' willingness to comply with their treatment regimens, family support capabilities and anticipatory deaths are all factors in a group inclusive of deaths outside the confines of the hospital. The ultimate cause of death still remains inconclusive in some cases where patients died after discharge from the hospital.

We have an ongoing internal monitoring system which includes both Hospital and Medical Staffs that review every death occurring in our hospital for the appropriateness and quality of the care given. Mortalities in this report have already been scrutinized, but any data to further identify subgroups of patients will be reviewed.

In summary, we continue to feel that it is important to communicate meaningful information to consumers about the quality of health care and related health care services.

Yours truly,

A handwritten signature in dark ink, appearing to read "Richard Carter", with a stylized, flowing script.

Richard G. Carter
Senior Vice President, Operations

RGC:cp



MIDWAY HOSPITAL MEDICAL CENTER

5925 San Vicente Boulevard, Los Angeles, California 90019 • (213) 938-3161

JEG-ED87-473

October 26, 1987

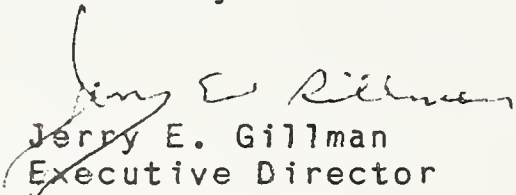
Mr. Harvey Brooks
Division of Program Operations
Health Care Financing Administration
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Mr. Brooks:

Midway Hospital Medical Center acknowledges the receipt of the Mortality Statistics compiled for our facility, (050477).

It appears that the actual Mortality Rates for Midway Hospital are within the predicted range of Mortality Rates for the various diagnostic categories listed. We appreciate the opportunity to review and comment on the data prior to the publication.

Sincerely,


Jerry E. Gillman
Executive Director

JEG/eg



MIDWOOD COMMUNITY HOSPITAL

7770 Katella Avenue • Stanton, California 90680-9990

(714) 527-7744 • (714) 898-0300

October 21, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Doctor Roper:

Thank you for this opportunity to respond to the release of the 1986 data on hospital mortality rates for Medicare beneficiaries. Since receiving our copy of the report, Midwood Community Hospital has had an opportunity to review the data.

The Director of Medical Records has validated that, with one minor exception of a patient we could not identify as having been at this hospital, the patient listing is accurate. The hospital specific mortality data has been carefully reviewed by: the Hospital Administrator, Chief of the Medical Staff, the Board of Directors, the Director of Medical Records and Quality Assurance Coordinator.

An initial in-depth analysis of the data was prepared, for the Board of Directors, by the Quality Assurance Coordinator. In this analysis she broke down the data in several different ways, looking for any trends or a level of care lower than we would like. Some of these displays included: High risk vs. low risk deaths; number of deaths by diagnosis category; deaths after discharge broken down by number of days after discharge; deaths by age range of the patient and number and percentage of deaths by individual physician. These reports were reviewed by the Board of Directors, which includes the Chief of the Medical Staff and several of the key physicians in the facility. The Board of Directors could see no specific areas of concern in the data presented.

The Medical Staff at Midwood Community Hospital conducts an intensive review of the medical records of every patient who expires at this facility. The review focuses on medical management and overall quality of care. Mortality review is an on-going part of the Quality Assurance Program and peer review activities are an integral part of the monitoring of the healthcare delivery system at this hospital.

FULLY ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

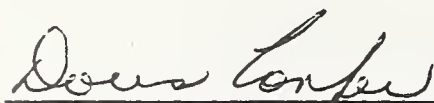
We appreciate the fact that, this year, you have identified our patients who expired within thirty (30) days of discharge from the hospital. This is the first time that we have had the opportunity to review this type of information so that we can follow up with a quality of care review on those patients. At the present time, we have sent follow up letters to the attending physician on each of those cases. The results will be reviewed by the appropriate clinical departments (ie, Surgery, Medicine) and the Board of Directors.

Your data did identify one diagnostic category where our mortality rate was one percent above the top of the predicted range for that category. These records will all be reviewed to assure that they were assigned to the correct diagnostic category. All of the individual cases/records will be reviewed by our Department of Medicine and a report of the findings made to the Board of Directors.

Since Midwood Community Hospital does treat a high volume of Medicare patients, we are pleased that our mortality rates were within the predicted ranges, with that one exception. We believe that the monitoring systems which we have in place provide us with continuous feedback in an effort to meet and exceed quality care standards. Our Medical Staff devotes many hours in a constant endeavor to identify opportunities to improve patient care.

Again, thank you for the opportunity to present this response. If you or anyone receiving this information has questions, please do not hesitate to call.

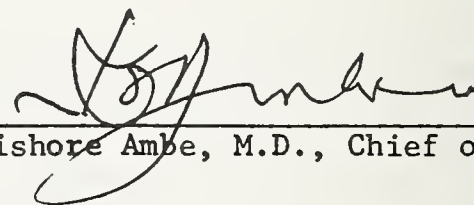
Sincerely,



Doris Confer, Administrator



Stanley Mayberg, M.D., Chairman,
Board of Directors



Kishore Ambe, M.D., Chief of Staff

Monterey Park Hospital

October 29, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
6300 Security Blvd., Room 202
Meadows East Bldg.
Baltimore, MD 21207

Attention: Harvey Brooks

RE: MONTEREY PARK HOSPITAL'S 1986 MORTALITY DATA RELEASE

Gentlemen:

Thank you for this opportunity to respond to the release of data on hospital mortality rates for January 1, 1986, through December 31, 1986. Since receiving the report dated September 21, 1987, Monterey Park Hospital staff has had an opportunity to review the data.

The Director of Medical Records has validated that, with minor exceptions, as noted below, the data is accurate. The Quality Assurance Director has reviewed all cases reflected in this report.

On an ongoing basis, appropriate clinical departments have always reviewed every mortality in our facility for appropriateness of care. Our hospital has a comprehensive, ongoing Quality Assurance Program which identifies problems and works to resolve them as quickly as possible. Support for these activities by our Medical Staff is evidence of their commitment to high quality patient care.

Based on a comprehensive review of the data and the specific medical records it reflects, we are confident that you and any member of the public who requests a copy of our statistical information will be interested in our summary report.

The following summarizes our findings:

The data used by HCFA indicate that a total of 868 Medicare patients admitted to Monterey Park Hospital 89 expired within 30 days of admission. Of these, 64 died while still a patient of the hospital, while 25 died after discharge. From our review, there were three additional patients who expired in our facility who should have been included in the statistics and are indicated in the enclosure accompanying this letter.

As to the accuracy of the diagnostic or other data used in your analysis, without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, verification is impossible.

In three of the diagnostic categories, the hospital's actual mortality rate is below the range of the predicted mortality rate as indicated below. In all other categories the hospital was within the predicted rate ranges.

Severe trauma - Predicted mortality rate - 1 to 37% -
MPH Actual mortality rate - 0%

Comment: We do not treat severe trauma cases.

Low Risk Heart Disease - Predicted mortality rate - 2 to 11%
MPH Actual mortality rate - 1%

Comment: The hospital's percentage reflects care which is consistent with the standards in the community.

Severe Chronic Heart
Disease - MPH Actual mortality rate - 5%
Predicted mortality rate - 12 to 37%

Comment: Traditionally, our physicians do not admit high risk cardiac patients as evidenced by the data. They determine those patients requiring an intensive level of cardiac care and transfer them to an appropriate tertiary care facility offering the services that these high risk patients require.

The Medical Staff of Monterey Park Hospital, as has been their practice, will continue to review all mortality cases for quality and appropriateness of care rendered to the individual patient. Trending analysis from these reviews is a constant endeavor to assist in identifying opportunities to improve care.

Again, thank you for the opportunity to present this response. If you or anyone receiving this information has additional questions, please do not hesitate to call.

Sincerely,


Reggie Panis
Administrator

RP:dlc

cc: Michael Keisling
Lin Baker
Ellie Pino
Hollis Apel
Chris Goette

MEDICARE PATIENTS NOT INCLUDED IN DATA

Three of the Medicare patients not included in the statistics were:

<u>PATIENT</u>	<u>SURNAME</u>	<u>DC</u>	<u>AGE</u>	<u>SEX</u>	<u>DATE DC</u>	<u>DATE DTH</u>	<u>PD</u>	<u>PROC</u>
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	5/1/86	5/17/86	5570	4562
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	11/28/86	12/4/86	1972	9904
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	5/28/86	6/18/86	585	8703

Mount Zion Hospital and Medical Center



1600 Divisadero Street, San Francisco/Telephone (415) 567-6600
Mailing Address: Post Office Box 7921, San Francisco, California 94120-7921

October 26, 1987

Dr. William L. Roper, Administrator
Health Care Financing Administration
6325 Security Blvd.
Baltimore, Maryland 21207

Mount Zion Hospital provider # 050033

Dear Dr. Roper,

Mount Zion Hospital and Medical Center welcomes the opportunity to respond to HCFA's mortality report for the period of 01/1/86 to 12/30/86.

Mount Zion, a major teaching affiliate of the University of California, San Francisco, is an urban, acute-care medical center. The aged and low income segments of the population we serve are frequently admitted with more serious illnesses and complications than other patient populations. For the time period represented in HCFA's data, 36% of Mount Zion's acute care discharges were Medicare patients and 22% were Medicaid. In addition, Mount Zion has a well-known, established cancer program to which many patients with advanced stages of disease are referred.

Review of the statistics indicates that Mount Zion's actual mortality rate did not exceed HCFA's predicted range in any of the diagnostic categories. Indeed, in many instances our rates were at the lower limits.

Mortality rates alone do not reflect the quality of care at any hospital. On an ongoing basis, our Quality Management component in conjunction with the medical staff reviews every death in our facility to monitor the quality and appropriateness of care given and to intercede when necessary.

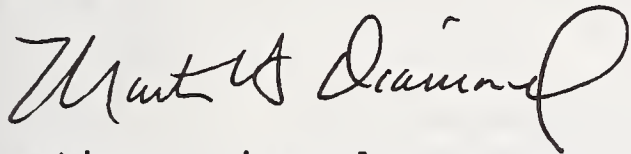
Constituent Agency of The Jewish Community Federation of San Francisco, Peninsula, Marin and Sonoma Counties

Page two
Dr. William Roper

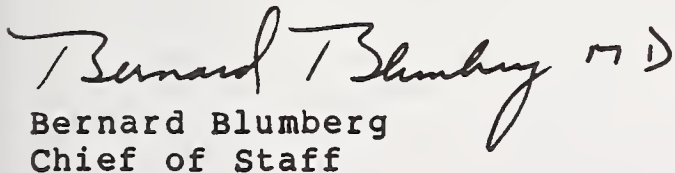
Mount Zion believes publication of useful, reliable information about quality healthcare is in the public interest. Our concern about releasing mortality data lies in the fact that it is likely to be interpreted as a measure of quality care. We do not believe that is correct. Mortality data is helpful in guiding or focusing peer review. Quality of care is of enormous importance to our medical staff, management and governing board. Any indication of a potential problem results in prompt review.

Thank you for the opportunity to present this written response. If you or anyone receiving this material has additional questions, please do not hesitate to call.

Sincerely,

A handwritten signature in cursive script, appearing to read "Martin H. Diamond".

Martin H. Diamond
President & Chief Executive Officer

A handwritten signature in cursive script, appearing to read "Bernard Blumberg" followed by a small mark that looks like "MD".

Bernard Blumberg
Chief of Staff



MT. DIABLO HOSPITAL MEDICAL CENTER

Michael L. Wall
Chief Executive Officer

BOARD OF DIRECTORS

Jason Appel, M.D.
President

John J. Baie
Vice President

Mary Louise Mahoney
Secretary-Treasurer

Arthur F. Bacigalupo
Director

Harry F. Bowers
Director

October 22, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

RE: HCFA Mortality Statistics for Mt. Diablo Hospital Medical Center,
Medicare Provider #05-0496

To Whom it May Concern:

In accordance with Dr. William L. Roper's letter of September 21, Mt. Diablo Hospital Medical Center hereby submits its written comment regarding the hospital-specific mortality data scheduled for public release by HCFA in December, 1987. We respectfully request that this written comment be included in its entirety in the final publication of Mt. Diablo's mortality data.

Thank you for the opportunity to review and comment upon this information prior to its release.

Sincerely,

Michael L. Wall
Chief Executive Officer

MLW/mda

Attachment (1)

2540 East Street, Concord, CA 94520-1960 415-682-8200

OPERATED BY THE MT. DIABLO HOSPITAL DISTRICT



MT. DIABLO HOSPITAL MEDICAL CENTER

Michael L. Wall
Chief Executive Officer

BOARD OF DIRECTORS

Jason Appel, M.D.
President

John J. Baie
Vice President

Mary Louise Mahoney
Secretary-Treasurer

Arthur F. Bacigalupo
Director

Harry F. Bowers
Director

COMMENT TO ACCOMPANY
MEDICARE MORTALITY STATISTICS
FOR MT. DIABLO HOSPITAL MEDICAL CENTER
MEDICARE PROVIDER NUMBER 05-0496

Thank you for the opportunity to comment on the 1987 HCFA data release regarding mortality rates among Medicare beneficiaries.

Our team of physicians, nurses, Quality Review Specialists and administrators has carefully reviewed the data concerning our Hospital. We believe that the mortality figures in this release reflect the high quality of care provided to patients at Mt. Diablo Hospital.

The first line of the report shows how Mt. Diablo's over-all mortality rate compares to the rate HCFA would have expected among patients similar to ours. HCFA predicts that Mt. Diablo's overall rate should fall within a range of 10 to 16 percent. Our actual rate of 11 percent is very favorable because it lies at the lower end of the predicted range.

HCFA then predicts mortality rate ranges for each of 16 diagnostic categories. As in the case of our over-all rate, Mt. Diablo consistently ranks favorably, in the mid or low end of the range in each category. We are particularly pleased that our mortality rates are quite low in Mt. Diablo's specialty areas, such as heart, cancer and renal disease.

Mt. Diablo Hospital Medical Center has a staff of 500 physicians and surgeons who represent every specialty and sub-specialty in medicine. Our 303-bed, full service facility serves a suburban area in Northern California with a half-million residents. Mt. Diablo functions as a referral center for the treatment of heart disease, cancer and renal problems. Our Northern California Heart and Lung Institute provides heart surgery, cardiac catheterization and balloon angioplasty (PTCA). Our Regional Cancer Center offers comprehensive cancer diagnosis and treatment. Mt. Diablo has two sites dedicated to outpatient hemodialysis and is the sole provider of these services in Contra Costa County.

In addition to these specialty services, Mt. Diablo provides a full range of inpatient and outpatient health care services, including alcohol and drug dependency treatment, 24-hour emergency staff, health promotion instruction, a physician-supervised weight loss program, two community-based urgent care centers, a pain management clinic, inpatient and outpatient eating disorders treatment, and an array of home health care services, including Hospice and an emergency response system for the frail and handicapped. We also offer numerous education programs and support groups for our patients and the

2540 East Street, Concord, CA 94520-1960 415-682-8200

OPERATED BY THE MT. DIABLO HOSPITAL DISTRICT

CA 317.1

Comment to Accompany
Medicare Mortality Statistics
for Mt. Diablo Hospital Medical Center
Medicare Provider Number 05-0496

general public.

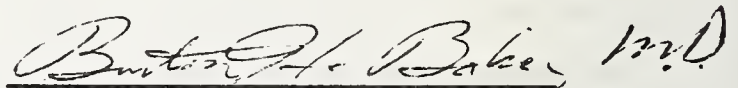
We are pleased to note that the approach HCFA has taken this year addresses some of the flaws apparent in the model used in 1986. We share the concern HCFA expresses in the August 17, 1987, Federal Register, that the model still does not capture one of the key factors affecting the probability of death: severity of illness. We would encourage further work on this variable because a hospital that serves the very ill can reasonably be expected to have a higher mortality rate.

Mt. Diablo continues to be dedicated to high quality care for all its patients, Medicare and non-Medicare alike. Our Hospital has an on-going Quality Review program in which all facets of patient care, including mortalities, are examined. Our evaluation system involves personnel at all levels, including our governing board, physicians, nurses, department managers and administrators.

Mt. Diablo welcomes inquiries about its services for Medicare patients. Please call Al Staton, Assistant Administrator, at (415) 674-2004 with any questions you might have.



Michael L. Wall
Chief Executive Officer



Burton H. Baker, M.D.
Chief of Staff

DEPARTMENT OF VETERANS AFFAIRS

VETERANS HOME OF CALIFORNIA

YOUNTVILLE, NAPA COUNTY, CALIFORNIA 94599

Telephone: (707) 944-4716



October 20, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for the opportunity to respond to the release of data on our hospital mortality rates during 1986.

Our medical records officer and utilization management staff are in the process of validating the information received. All deaths at our facility are reviewed by the medical staff on an ongoing basis, and this data will be correlated with their findings.

It is noted that the overall mortality rate at this facility falls within the range of predicted values as calculated by your statistical staff, and the mortality rate for all diagnostic categories listed with the exception of 2, severe acute heart disease and pulmonary disease also fall within the predicted ranges. Our quality assurance staff, which is made up of physicians, nurses and medical records personnel, are reviewing again the deaths in these two categories and will share its findings with the administration and medical staff of this facility.

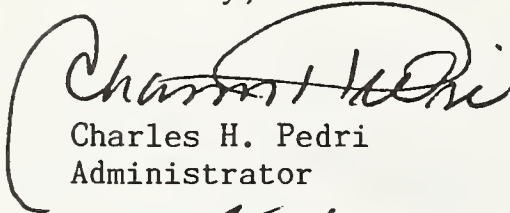
We would like to share with you a brief overview of the population base we serve at this hospital. Ours is a 30 bed acute medical/surgical unit designed to care for the acute medical needs of our entire "community" which is a 1400 bed domiciliary and long term care facility for aged and debilitated veterans of our country's wars. The average age of our population is 72 years old and most veterans who choose to reside here have multiple, disabling medical conditions requiring close medical and nursing supervision. The mortality data presented must be viewed in the context of this population description and cannot be compared with that from other general hospitals serving a more average community population.

William L. Roper, M.D.
October 20, 1987
Page Two

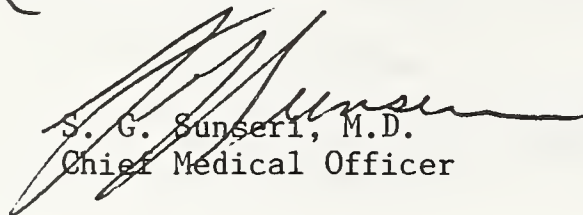
The medical staff along with the administrative staff will continue to conduct a comprehensive monitoring of all patients and every death at this facility so that high quality management is assured. While the mortality data presented is but one measure of care, we welcome this additional information as part of our ongoing quality assurance program.

Thank you for the opportunity to present this response.

Sincerely,



Charles H. Pedri
Administrator



S. G. Sunseri, M.D.
Chief Medical Officer

CH:SGS:pag

ENLOE HOSPITAL

"A CALIFORNIA NONPROFIT CORPORATION"

JAMES P. SWEENEY
Executive Director

"BUILDING TOWARD YOUR BETTER HEALTH"

Approved by the
Joint Commission on
Accreditation of Hospitals

W. 5th Avenue and The Esplanade Chico, California 95926 (916) 891-7300

October 22, 1987

Dr. William L. Roper
Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
Post Office Box 26684
Baltimore, MD 21207

Dear Dr. Roper:

This letter is to provide comments and response to the hospital specific selected mortality data prepared by Health Care Financing Administration (H.C.F.A.) of Medicare patients treated during 1986.

Before commenting, some descriptive information about Enloe Hospital will be useful. First, Enloe Hospital is classified by the California Health Facilities Commission as a Large Complex hospital. Enloe Hospital is the only hospital in Health Systems Area (HSA) 1 with this designation. The classification is based, in part, on Enloe Hospital's broad range of specialized services, such as Open Heart Surgery, Cardiac Catheterization Laboratory, Radiation Therapy, Neurosurgery, and Flight Care (our Helicopter Service).

Second, Enloe Hospital has many Medicare patients in Diagnosis Related Groupings with high case weights. The result is a hospital-wide Medicare case-mix index of 1.45. This case-mix index is among the highest 3% in the United States.

Third, Enloe Hospital has a high proportion of intensive care services. Enloe Hospital has five (5) adult intensive care areas:

- Acute Respiratory Care
- Coronary Care
- Intensive Care-Medical
- Intensive Care-Neuro/Neurosurgical
- Intensive Care-Trauma/Surgical

These five (5) units have a total of thirty-three (33) beds. In addition, there are twenty-three (23) beds in a "step-down" unit providing a level of care between intensive and general medical-surgical care. Also, Enloe Hospital has thirty-two (32) telemetry cardiac monitors.

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Dr. William L. Roper
October 22, 1987

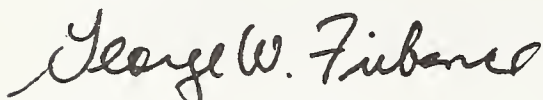
Page Two

Fourth, Enloe Hospital admits patients from a large geographic area. Cancer, cardiac, and respiratory patients, as well as others, are referred to specialists in Chico. Patient origin studies show one third of Enloe Hospital's patients reside in Chico, one third reside elsewhere in Butte County, and the remaining one third reside outside Butte County.

These factors demonstrate that Enloe Hospital provides diagnostic and treatment services to patients from a large geographic area, who have a high level of medical complexity and severity of illness.

According to the statistical model, during 1986, H.C.F.A. expected that Enloe Hospital would have a mortality rate between 9 and 15 per cent. With the type of patients based on age, sex, previous hospitalizations, primary diagnosis, and secondary diagnoses and with Enloe's high level of medical complexity and intensity of care, Enloe Hospital's actual experience was consistent with the H.C.F.A. expected experience.

Sincerely,



George W. Fribance
Assistant Administrator

lj

c: Ms. Karen Logsdon
Senior Vice President
California Hospital Association

Ms. Carol M. McCarthy, Ph.D., J.D.
President
American Hospital Association

David Schlichting, M.D.
Chief of Medical Staff
N. T. Enloe Memorial Hospital

October 23, 1987

William L. Roper, M.D.
Administrator
Department of Health & Human Services
Health Care Financial Administration
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

We have reviewed the 1986 Medicare Mortality data supplied by the Department of Health & Human Services.

While NorthBay Medical Center showed no significant deviation from the range of predicted mortality rates, we would like to briefly comment on the diagnostic category of sepsis.

The predicted mortality range is 17 to 75%. Our actual mortality rate was 78%. First, it should be noted that the total number of cases is too small to draw accurate conclusions. Secondly, it should be noted that the majority of the patients were septic on admission, were transferred from nursing homes and had multiple, long term diagnoses which played a large part in their deaths.

Questions about the data should be directed to Taml C. Morris, Vice President for Public Relations at 707/429-7979.

Sincerely,



Gary J. Passama
President

GJP:11
2075n



**Northridge Hospital
Medical Center**

18300 Roscoe Boulevard
Northridge, California 91328
(818) 885-8500

October 29, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Gentlemen:

Thank you for the opportunity to provide input regarding Northridge Hospital's mortality statistics for the calendar year 1986.

Northridge Hospital Medical Center is a 345 bed acute hospital which serves as a referral center for patients suffering major acute illnesses requiring specialized services in Cardiology, Cardiovascular Surgery, Cancer, End-Stage Renal Disease and other major acute illness, as well as to victims of trauma and severe emergency problems.

A review of the data for this hospital indicates that the mortality rate in all areas reported is within the predicted ranges.

The Medical Staff of Northridge Hospital continues to review and assess the care of all patients admitted to this hospital. We believe that the quality assurance activities conducted by the hospital and the medical staff assure that every patient receives the most current medical care that it is possible to render.

Sincerely,

Jeffery E. Flocken
Administrator

Harry Knaster, M.D.
Chairman, Patient Care
Assessment Committee



NOVATO
COMMUNITY
HOSPITAL

October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing
Administration
Department of Health &
Human Services
Washington, D. C. 20201

RE: Response to HCFA Mortality Data Release
Novato Community Hospital Medicare
Provider Number 050131

Dear Dr. Roper:

Thank you for this opportunity to respond to the HCFA release of mortality data. We welcome the information provided by HCFA and we agree with HCFA that this information should not be used as the basis for judging the quality of care provided by a hospital.

Novato Community Hospital's mortality rates fall within the predicted ranges in all but one category: "Severe acute heart disease." The following factors may account for this:

1. The category itself is high risk and a high incidence of death as the outcome is expected.
2. HCFA data show only 17 patients in this category. Numbers of patients less than 100 are too small to be statistically significant.
3. Our records indicate 37 discharges in the category. We are unable to verify how the HCFA data numbered only 17. Presumably this discrepancy reflects multiple admissions of individual beneficiaries with last admissions in other categories or hospitals.

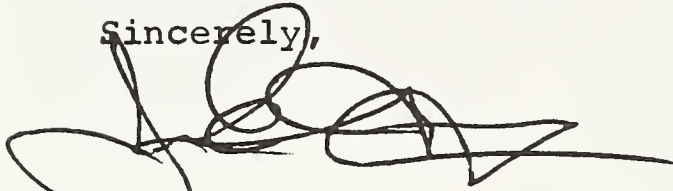
1625 Hill Road, Novato, CA 94947 415/897-3111

An Affiliate of Sutter Health System

Response to HCFA Mortality Data Release
October 23, 1987
Page 2

HCFA data is not the final measure of hospital performance. At best, this data can be used to better focus quality assurance activities. As with all deaths that occur in this hospital, the peer review physician committees have reviewed these cases and found the care to be appropriate in each instance.

Sincerely,

A handwritten signature in dark ink, appearing to be "Joel E. Grey", written over a horizontal line.

Joel E. Grey
Administrator

JEG:cwc



O'CONNOR HOSPITAL

October 21, 1987

William L. Roper, M.D.
Administrator
Department of Health & Human Services
Health Care Financing Administration
Washington, D.C.

Dear Dr. Roper:

Thank you for giving us the opportunity to review and comment on the mortality data for Medicare patients admitted to O'Connor Hospital in 1986.

The Directors of Medical Records and Quality Management/Utilization Review have validated that the data is accurate. On an ongoing basis, appropriate Departments and Committees of the Medical Staff review every death in the hospital for appropriateness of care. Through this and other Quality Assurance activities we were aware that our mortality (and morbidity) data was comparable to other acute care hospitals providing like specialty services to a similar mix and acuity of patients. The HCFA data which compares actual deaths to predicted deaths for this population of patients adds an additional perspective.

We note that the mortality rate for O'Connor Hospital in each of the sixteen diagnostic categories is well within the range of predicted mortality rates for each category.

In view of this it may be of interest to note that O'Connor Hospital is a 395 bed general acute care hospital offering the following specialty services:

- o Cardiovascular - Noninvasive Cardiology, Cardiac Catheterization Laboratory, Open Heart Surgery, Critical and Progressive Nursing Care Units.
- o Cancer Care - Radiology, Ultrasound, CT Scan, Nuclear Medicine, Radiation Therapy, Oncology and Hematology Unit and Hospice.
- o Basic Emergency Service.
- o Intensive Care - including acute dialysis unit.

- o Surgical Services - including 10 operating rooms for General and Specialty Surgery, Endoscopy, Ophthalmic Diagnostic Unit and Ambulatory Surgery Program.

We will continue to monitor quality and appropriateness of care on an ongoing basis. We are pleased that HCFA's data substantiates all other indicators of high quality and appropriateness of care at O'Connor Hospital.

Thank you for providing us with an opportunity to comment.

Sincerely,



Kathy Rowan
Vice President
Professional and Support Services

/mn



Ojai Valley Community Hospital

1306 Maricopa Highway • Ojai, California 93023 • (805) 646-1401

October 23, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

To whom it may concern:

We are in receipt of the Hospital Mortality Information for 1986.
Since our statistics are within acceptable ranges, we will not be forwarding a formal response.

Sincerely,

Jane D. McCarthy
Director of Development

Accredited by the Joint Commission on Accreditation of Hospitals



Ontario Community Hospital

550 N. Monterey Avenue
Ontario, CA 91764
(714) 984-2201

Richard J. Forrester
Chief Executive Officer

October 27, 1987

William L. Roper, M.D.
Administrator
Department of Health and Human Services
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for this opportunity to respond to the release of data on hospital mortality rate for 1986. Since receiving the report, our medical staff has reviewed the mortality statistical data and all medical records reflected in this report.

Our Medical Records Department has validated that, with some exceptions, the data is accurate. The following summarizes our findings:

1. 16% died outside of the hospital, either at the patient's home or in an extended care facility.
2. In 52% of the cases, the patient's family ordered no cardiopulmonary resuscitative efforts.
3. In over 76% of the cases the patient's age was over 70.
4. All cases cited involved co-morbidities.
5. 77% were admitted through the E.R. in an acute state of the disease process.

It is also noted that as part of our Quality Assurance Program, every mortality in our facility is reviewed for quality and appropriateness of care by the appropriate medical staff departments on an ongoing basis.

We believe that our monitoring system provides us with a continuous feedback mechanism in an effort to continue to meet and exceed high quality care standards.

Sincerely,

Richard J. Forrester
Chief Executive Officer

RJF:dd

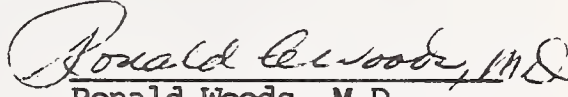
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6. Severe acute heart disease: Average age of Patient 77 years.
 - ° The most common cause of death in this category was acute myocardial infarction with shock.
 - ° Majority of these patients were emergency admissions in critical condition and with other complicating medical problems present in a significant number of cases, i.e., renal failure, diabetes and hypertension.
7. Orthopedic Disorders: Average age of patient 75.2 years.
 - ° Two patients or 50% of the patients identified in this category did not have an orthopedic diagnosis and were mis-classified in the HCFA data.
 - ° Our actual orthopedic mortality rate is 1%. We treated 279 Medicare patients and had 2 deaths. Both of the deaths that occurred were patients admitted from nursing homes with fractured hips and multiple medical problems.
8. Renal Disease: Average age 73.0.
 - ° Review revealed these were patients in end-stage chronic renal failure, on dialysis, with multiple medical problems.

Thank you for the opportunity to present this response.

Sincerely,


Russell Stromberg,
Hospital Administrator


Ronald Woods, M.D.,
Medical Staff President

RSS:pp
#14L.6,7&8



October 20, 1987

Dear Interested Parties:

Oroville Hospital is pleased to have this opportunity to respond to the Health Care Financing Administration release of 1986 hospital specific Medicare mortality data. Review of the data indicates that Oroville Hospital's actual Medicare mortality rate is well within the range predicted for Oroville Hospital for all diagnostic categories.

Oroville Hospital is 99 bed acute care, full service hospital offering care in specialty areas of oncology, major orthopedic services, intensive care services, as well as general medicine and surgery. Oroville Hospital also provides Advance Life Support and Emergency Trauma Care for the area. Oroville Hospital's Emergency services are the highest utilized in Butte County. In addition, Oroville Hospital is the sole general acute-care hospital, serving the Hospice of Oroville, and most of the terminally ill patients are admitted to the hospital as the time of death becomes imminent.

Oroville Hospital conducts a thorough review of medical management and the overall care of every patient. Mortality review is an on-going process of the quality assurance program and peer review activities are an integral part of the monitoring of health care delivery system at this hospital. The Joint Commission on Accreditation of Hospitals has bestowed on this facility its highest commendations in the form of continued accreditation status.

Each patient death is a unique loss and a matter of great concern to the patient's family, friends and acquaintances, in addition to the patient's physicians, nurses, therapists and other professionals who provide care for the ill and the injured. Obviously, each death is also a very emotional event for everyone involved.

Again, thank you for the opportunity to append this statement to the release of mortality data for Oroville Hospital 1986.

ROY C. SHANNON, M.D.
CHIEF OF STAFF

ARDEN BENNETT
ADMINISTRATOR

OrthopaedicHospital

2400 South Flower Street
Los Angeles, California 90007
Telephone: 213-742-1000
Mailing Address:
P.O. Box 60132, Terminal Annex
Los Angeles, California 90060



October 26, 1987

Dear Friends of Orthopaedic Hospital:

Thank you for this opportunity to respond to the release of data on the 1986 hospital mortality rates.

The medical staff "Quality of Care" committee conducts extensive review of the medical record of every patient who expires at this facility regarding the medical management and overall care. Mortality review is an ongoing process of the medical staff committees and an integral part of the monitoring of the health care delivery systems at Orthopaedic Hospital.

Please note that there is a duplicate entry of Patient identification numbers and information on the HCFA Mortality Data Release. Therefore, the adjusted number of deaths for Orthopaedic Hospital is 4 out of 291 admissions representing a mortality rate of 1.3%, well below the Los Angeles mortality rate of 6.7% .

The following summarizes our findings on each of the four patient deaths by DRG.

DRG 082 = Respiratory Neoplasm
Probable Cancer of the lung with metastases

- * The predicted percent of deaths for DRG 082 in Los Angeles is reported as 25% and our facility rate is 25%. This represents 1 death during the review period
- * Patient was admitted with diagnosis of Cancer of the lung
- * Caretakers requested "no code"

DRG 466 = Aftercare w/o history of malignancy as secondary diagnosis

- * 20 year patient of facility with a diagnosis of Hemophilia A
- * Admitted for control of bleeding following tooth extraction
- * Expired outside facility from complications of AIDS
- * This represents 1 death during review period

DRG 209 = Major joint and limb reattachment procedures

- * The predicted percent of deaths in Los Angeles in this category was reported 1.8% and our facility rate is 0.6%
- * This represents 1 death during review period in the joint replacement category which represents the major service provided at Orthopaedic Hospital.
- * The patient experienced a massive pulmonary embolism several days post surgery and did not respond to an aggressive resuscitative effort.

DRG 127 Heart failure and shock

- * This represents 1 death during study period
- * Family requested "no code" on the 89 year old patient

Again, thank you for this opportunity to clarify Orthopaedic Hospital mortality data.

Sincerely,



Jeffrey S. Kirschner
President and Chief
Executive Officer



Melvin Stoltz, M.D.
Vice President for Medical Affairs



**Pacifica Community
Hospital**

18792 Delaware Street
Huntington Beach, CA 92648
(714) 842-0611

October 27, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
Post Office Box 26684
Baltimore, Maryland 21207

Re: 1987 Health Care Finance Administration
Mortality Data Release

Dear Sirs:

We would like to take this opportunity to respond to Health Care Finance Administration's Mortality Data Release. Based on a comprehensive review of this data, we feel the following information will be of interest to HCFA and the public.

The overall patient census of Pacifica is comprised of 50 percent Medicare patients. This is largely due to the location of the facility. Within a one-mile radius of Pacifica, there are five extended care facilities, one large board and care, and one large retirement residence. We have determined that the average Medicare patient who is hospitalized at Pacifica is much older, has more than one major illness, and their general condition of health is fair to poor. This is reflected by an average age of 80 for the patients included in this data. The average age of Pacifica's patients has been shown to be four to six years higher than the state and southern region average age as shown in California Medical Review, Inc.'s, previous data releases. It is significant to note that 60 percent of these cases had requests for no extraordinary life sustaining measures by the patients or family.

The medical staff at Pacifica has carefully reviewed each mortality case represented in the data. They have determined that each patient received the very best care possible. It was noted that our overall mortality rate was within the predicted range, at 16 percent.

The data included all patients who died within 30 days of hospital admission. Thirty-three of these cases died outside the facility, or, rather, after discharge. Of these cases, 22 patients were discharged to home or a skilled nursing facility in a terminal condition, at the request of the patients and/or

their families. Eleven cases were discharged in stable condition but expired due to multiple health problems and advanced age. One case was transferred to another acute hospital for cardiac surgery and expired.

In the category of severe acute heart disease, our actual mortality rate is 5 percent over the predicted range. It is noted that the average age of this group is 79 years.

There were 16 deaths in this category, one of which died in another acute facility following transfer. Seven of these patients were from skilled nursing facilities and had extensive histories of heart disease. Six patients in this category died within one day of admission due to cardiac arrest. There were five cases in which the families had requested no heroics or life sustaining measures due to patient's advanced age and terminal condition.

The remaining categories were noted to be within the predicted range. Following careful review of each case, it was determined by the medical staff that all patients received good-quality care.

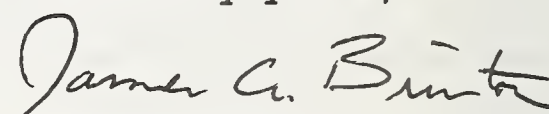
On an ongoing basis, the medical staff of Pacifica Community Hospital will continue to evaluate and review all deaths, regardless of payor source, in the peer review setting, to maintain high standards of patient care. Pacifica will continue to evaluate and educate the medical staff in order to respond to the needs of patients and the community.

Sincerely yours,



Philip P. Gustafson
Executive Director

Sincerely yours,



James Brinton, M. D.
Chief of Staff

PPG:pg

PACIFIC HOSPITAL



OF LONG BEACH

2776 PACIFIC AVENUE • LONG BEACH • CALIFORNIA 90806
(213) 595-1911

October 23, 1987
Medicare Provider No. 05-0277

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Dear Dr. Roper:

Thank you for giving us an opportunity to comment on your mortality data for this hospital for 1986.

Before reviewing the data you provided, I should point out two mistakes in reporting:

- [REDACTED] died in the hospital. Her date of discharge and date of death should both be reported as 09/07/86.

[REDACTED] died in the hospital. Her date of discharge and date of death should both be reported as 04/03/86.

I would also like to note for the record my grave concerns about the validity of the statistical techniques used and whether they accord adequate weight to the patient's acuity or severity of illness on admission. While patient demographics have been factored in, patient acuity has a major impact on the predictability of the outcome.

That said, I have the following comments on the data:

While none of the reporting categories exceeded the range of your predicted mortality rates, our Medical Staff did critically review all death charts in those categories in which we approached the upper limits of your ranges. (These charts were re-reviewed as the charts of all patients who die in the Hospital are reviewed by our quality assurance staff, our Patient Care Monitoring Committee and by the appropriate medical departments to assure that the patient received the best possible care and that the death was unavoidable.)

William L. Roper, M.D.
Page 2
October 23, 1987

- Severe chronic heart disease: Of the 17 deaths in this category, 15 died in the hospital. The majority were "no code" patients, at the request of the patient or his family, with severe comorbidity such as end-stage lung disease and end-stage renal disease. The "no code" status of such a high proportion of these patients means that imminent death was unavoidable.
- Pulmonary disease: Of the 29 deaths in this category, 27 were admitted through our Emergency Room and most of these from area nursing homes. The majority of these patients had concomitant end-stage lung disease, heart disease or liver disease. Thirty percent also suffered from metastatic carcinoma.
- Sepsis: Of the 11 deaths in this category, 10 were admitted through our Emergency Room. Eighty percent had multiple organisms in their blood; sixty percent were classified as "no code," and forty percent had such overwhelming infection that they died within 24 hours of admission.
- Urologic Disease: Of the 9 deaths in this category, 8 were admitted through our Emergency Room from area nursing homes. All suffered from serious concomitant disease including congestive heart failure, diabetic acidosis, cancer, and renal failure. On review, none of these deaths was avoidable.

We appreciate the data you have provided and the ability to measure our activity against benchmarks, however imperfect. Focusing on those few areas where our results were within the norms you have established, but on the higher end of those norms, has served to validate the ongoing peer review activities at the hospital and the effectiveness of our quality assurance activities.

Yours truly,


Gerald S. Goldberg
Administrator

Pacific Hospital of Long Beach

GSG:ws

October 22, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Re: Palm Drive Hospital Response to HCFA Mortality Rate
Information - Hospital I.D. #050385

The mortality rate data for Palm Drive Hospital has been received and reviewed. The following are comments based on that review:

Although Palm Drive Hospital's mortality data falls within the predicted rates in all but one category, questions arise as to whether any valid conclusions can be drawn from these figures. Although mortality is not a desirable outcome in some cases, it should not be used as an indicator (in and of itself) of the quality and appropriateness of hospital care. Your cover letter indicated agreement and awareness of some of the problems with data interpretation and hopefully, this will be reemphasized when the data is released to the general public.

The review of our particular data focused on cancer patients which showed a slightly higher than predicted mortality rate for our hospital. Charts of these patients who died in our facility were again reviewed. (All deaths are routinely reviewed by the appropriate medical staff committees as an integral part of our hospital's Quality Assurance Program.) Out of twelve charts reviewed, eleven of these were expected deaths reflective of the advanced state of their disease. The mortality rate taken alone could be misleading to the consumer. Conversely, a lower than predicted mortality rate could present a misleading appearance of "good care" in situations where there are problems relating to case management, for example in facilities where there is not an effective mechanism for mortality review.

Health Care Financing Administration
October 22, 1987
Page 2

Again, emphasis should be placed on the fact that the principal "technical" issue is that the ability of the model to detect differences in quality has never been evaluated. The HCFA data assumes that each hospital's patients are average except with respect to a few characteristics included in the statistical model. The model does not include measures of severity, i.e., how ill the patient was at the time of admission; whether the patient was transferred to the hospital from a nursing home; whether the patient was receiving treatment at home prior to admission; whether the patient had a terminal illness. As a result, hospitals treating unusually large numbers of severely ill patients or with specialized programs for the terminally ill may have higher than predicted mortality rates. The hospital supports and applauds efforts made by health care providers, agencies and fiscal intermediaries to educate the consumer to assist him/her in making informed decisions regarding options in seeking medical care. We would only urge responsibility in assessing accuracy, completeness and usefulness to the consumer before such information is released.

Sincerely,


Vance Fager
Administrator

VF:rs



Palmdale Hospital Medical Center

Office of the Executive Director

October 2, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Washington, DC 20201

Dear Dr. Roper:

We would like to take this opportunity to respond to Health Care Financing Administration's current release of data regarding patient mortality within 30 days of their last hospital admission. Based on comprehensive review of this data, we feel the following information will be of interest to HCFA and the public.

During the year of 1986, our 30 day mortality rate was 552 cases, representing a 10% overall rate, which was within the range of predicted mortality rates published by HCFA. These cases were divided into 15 diagnostic categories and in all divisions our actual mortality rates were within the range of predicted mortality rates.

The professional staff at Palmdale has carefully reviewed each mortality case represented in the data. It has been determined that each patient had received the highest quality care possible.

On an ongoing basis, the Medical Staff of Palmdale Hospital Medical Center will continue to review all deaths, regardless of payor source, in the peer review setting to maintain high standards of patient care.

Based on our review of the yearly data, Palmdale Hospital Medical Center will continue to evaluate and provide for continuing education of the Medical Staff in order to respond to the needs of the patient, physician and the community we serve.

Sincerely,

Clark D. Todd, Jr.
Executive Director

CDT:cw

1212 East Avenue S • Palmdale, California 93550 • (805) 273-2211

An American Health Group International Facility
CA 345



PALOMAR POMERADO HOSPITAL DISTRICT

A PUBLIC ENTITY

October 22, 1987

President and
Chief Executive
Officer ROBERT M. EDWARDS

POMERADO
HOSPITAL

Executive Vice
President
Administrator VICTORIA M. PENLAND

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Re: Pomerado Hospital
#050636

To Whom It May Concern:

On behalf of Pomerado Hospital, I would like to take this opportunity to comment on the Statistical Report released by the Health Care Finance Administration regarding mortality data.

Review of the Pomerado Hospital statistics reveals 1,233 Medicare admissions in 1986, with an overall mortality rate of 11%. This rate falls well within the range of predicted mortality rates of 8 to 15%. In addition, the mortality rates for Pomerado Hospital in the 16 diagnostic categories listed in the report fall well within the range of predicted mortality rates for each category.

As always, Pomerado Hospital is committed to providing the best possible patient care. In doing so, Pomerado Hospital maintains a hospitalwide Quality Assurance Program to monitor the quality of patient care on an ongoing basis. The Quality Assurance Program includes a monthly review of all mortality cases. The Medical Staff, Administration, and hospital personnel participate in the program, which is ultimately accountable to the Board of Directors.

Any questions regarding the above should be directed to the office of Administration, (619) 485-4600.

Sincerely,

Victoria M. Penland
Executive Vice President
Administrator
Pomerado Hospital

cc: Robert M. Edwards
Mel Knoepp
Anita Reisman
Pam Taie

October 19, 1987

William L. Roper, M.D., Administrator
Department of Health and Human Services
Health Care Financing Administration
Washington, D.C. 20201

Dear Mr. Roper:

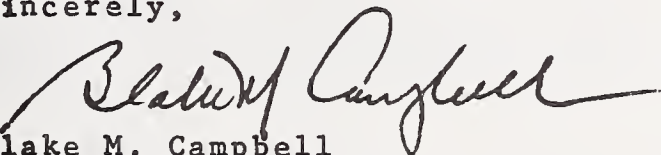
We are in receipt of the HCFA Mortality Statistics for Medicare patients treated in Panorama Community Hospital in 1986. We have studied and evaluated the material and would like the following comments to be distributed with our report to any requesting parties.

Of the sixteen (16) diagnostic categories, Panorama's actual mortality rate fell outside the predicted range in only one category; CE-Cerebrovascular Accidents. The average age of the patients in this category was 78.9 years. The majority of these patients had multiple system diseases prior to admission, including HTN, TIA's and CVA's. Both the age of patient and prior multiple system diseases are believed to be contributing factors to the patient's deaths.

HCFA's records indicate that six of the fourteen deaths occurred after discharge, however, our statistics show that this number should be five out of fourteen. Of those five patients, four were discharged to an Extended Care Facility.

We appreciate the opportunity to respond to HCFA's release of data on 1986 Hospital Mortality Rates and would be happy to answer any additional questions upon request.

Sincerely,



Blake M. Campbell
Chief Operating Officer

BMC:jj

cc: Steve Volla
Bill Price



PARADISE VALLEY HOSPITAL

October 27, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

2400 E. FOURTH ST.
NATIONAL CITY, CA
92050-2199
(619) 470-4135

To Whom It May Concern:

Paradise Valley Hospital, provider number 050024, appreciates the opportunity to provide a written response in advance of the Health Care Financing Administration's mortality data release in December.

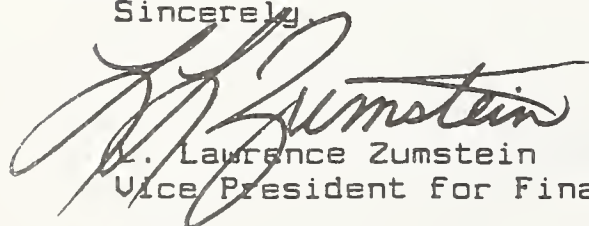
After study of the mortality report, we were pleased to note that Paradise Valley hospital fell within the predicted range for mortality in all except one category, severe acute heart disease. Of the 23 patients admitted with a diagnosis of acute heart disease, 10 of the patients were admitted over the age of 70. Seventy percent of those who expired were admitted to the hospital post cardiopulmonary arrest through the Emergency Room.

Paradise Valley Hospital serves a disproportionate share of Medi-Cal patients in the South Bay. In addition, the hospital serves the less economically advantaged population who are sicker and older. We have a Cancer Care Unit where the majority of patients are 65 years and older and suffer from end stage cancer. We also have an acute stroke/pulmonary rehab where the majority of patients are again, 65 years and older.

Our hospital has an Integrated Quality Assurance/Utilization Management program to assess and monitor the quality of care provided to each patient admitted to our facility. Quality Assurance/Utilization Management Department staff perform 100% concurrent chart review where identified problems are immediately referred to the appropriate persons, departments or committees to assure patient safety.

Please refer any questions you may have about the above information to me at (619) 470-4130.

Sincerely,



L. Lawrence Zumstein
Vice President for Finance

LLZ/vjb

October 23, 1987

Parkview Community Hospital



William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

3865 Jackson Street
Riverside, CA
92503
714-688-2211

Dear Dr. Roper:

Parkview Community Hospital welcomes the opportunity to respond to HCFA mortality rates for the period of January 1, 1986 through December 30, 1986.

Parkview Community Hospital reviews each death in the appropriate medical department as part of an ongoing Quality Assurance program. We believe our review procedures are excellent and our ongoing monitoring provides continuous feedback to ensure quality patient care. We at Parkview Community Hospital specialize in the care of patients with cancer through Curtis Cancer Center and encourage the community to refer the elderly from home and local convalescent facilities.

Our hospital was within the predicted mortality range in 15 out of 16 diagnostic categories. We are providing data to clarify the diagnostic category (cerebrovascular accident) which reflected a higher mortality rate than the predicted rate by 3%.

In 80% of the cases, the family or patient requested a do not resuscitate status. 60% of deaths in this category died at the hospital and the other 40% died within 30 days of admission. In view of the minor percent of variance from the predicted rate, and the average age of 85 years in these patients, we feel the death rate for cerebrovascular accident is not excessive.

It is the intent of Parkview Community Hospital to provide clear and concise information to you and other interested parties in a timely manner. Should you have any questions or need further information, please do not hesitate to contact us.

Sincerely,

Ferne Fannin
Executive Vice President/Administrator

Robert Barton, M.D.
Chairman, Quality Assurance Committee

cc: Willie Citrin, M.D., Chief of Staff, Parkview Community Hospital
Sam Digati, Chairman, Board of Directors, Parkview Community Hospital

FF/w
CMRI/1



October 23, 1987

William L. Roper, M.D.
DEPARTMENT OF HEALTH AND HUMAN
SERVICES
Post Office Box 26684
Baltimore, Maryland 21207

REFERENCE: Mills Hospital, #050302; Peninsula Hospital #050007

Dear Dr. Roper:

Thank you for sharing the 1986 mortality data with us prior to making it available to the public. This data does seem to be more accurate than the information we received last year. However, we feel very strongly that this data, which will go out to the general public, should have qualifying statements printed on the data sheets which read:

1. This data includes patients who have died within 30 days of admission either in the hospital or outside of the hospital and does not take into account that the patient may have died of an illness or injury which may have nothing to do with the reason for the admission to the hospital.
2. This data does not take into account patients who may develop a secondary illness, injury, or the severity of their present illness.
3. This data, as presented, is NOT AN INDICATOR OF QUALITY OF CARE.

The time period represented by this data should be listed somewhere on the data sheet. It would have given hospitals needed time for analysis of the comment period were longer than 30 days.

Thank you for letting us review this data prior to public release.

Sincerely,

ROBERT HORTOP
Vice President

RH:bjm

CA 351



PIONEER HOSPITAL

17831 SOUTH PIONEER BOULEVARD, ARTESIA, CALIFORNIA 90701
TELEPHONE (213) 865-6291

(Medicare Provider No. 050317)

October 19, 1987

Healthcare Financing Administration
Department of Health and Human Services
P.O. Box 26684
Baltimore, Maryland 21207

RE: HOSPITAL MORTALITY STATISTICS

Dear Healthcare Financing Administrator:

Pioneer Hospital appreciates the opportunity to comment on your report of mortality rates for Medicare patients in 1986. Pioneer Hospital is a 99 bed acute care hospital providing a wide variety of medical and surgical services since 1960. Each month, Pioneer Hospital and C.M.R.I. reviews all mortalities occurring in the hospital for appropriateness and quality of care.

Your data reflects that Pioneer Hospital's mortality rate from all causes is within the state range of mortality rates. Additionally, Pioneer Hospital's mortality rates for each of the sixteen causes of death are within each of the state ranges of mortality rates. Nevertheless, our Assistant Administrator of Medical Records and Quality Assurance and our D.R.G. Coordinator have reviewed these reported Medicare cases and we offer the following comments on your Mortality Report to ensure it is kept in perspective and its limitations are noted.

We cannot verify that [REDACTED] has ever been seen at Pioneer Hospital. A diligent search of our medical and financial records fails to establish that he was ever at Pioneer Hospital. We would respectfully request more identifying information on this patient.

[REDACTED] has an admission date not reflected in your report. You are correct that this patient had a prior admission at Pioneer from [REDACTED]. But, he was readmitted on [REDACTED], the day of his death. We would request that this data be corrected to reflect the [REDACTED] admission.

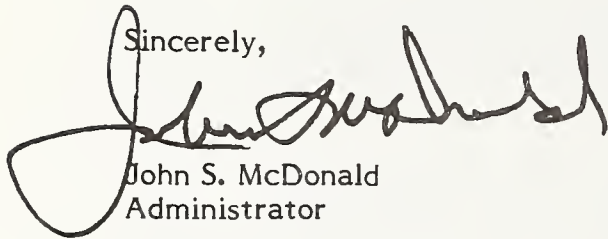
Seventeen patients are reported as dying outside of Pioneer Hospital. Each of these patients was discharged in the final stages of disease processes, which included congestive heart failure, serious heart attack, cancer of the brain, lung, stomach,

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and throat, acute respiratory failure and chronic obstructive pulmonary disease. Of these seventeen patients, only one was below the age of 65 and ten of the seventeen were over 75. Lastly, five of these seventeen patients were transferred to a skilled nursing facility (one patient refused a SNF), five were "No Code" status (life sustaining treatment to be withheld) and four came to Pioneer from a skilled nursing facility. This data reflects that Pioneer Hospital is increasingly caring for elderly patients in the final stages of their life.

This data points up a significant weakness with your reporting. Pioneer Hospital can only verify the patient's diagnosis on discharge and cannot reasonably verify the cause of death of these patients without contacting the family directly, as the physicians are often not informed of the patient's death. Additionally, this data indicates that your mortality report does not consider the patient's severity of illness prior to admission; whether that patient has come from a nursing home, another acute care hospital, the number of times the patient was admitted to our hospital prior to the last admission or whether the patient was sent to a skilled nursing facility. This information would have a significant impact on their length of stay and outcome in our hospital. Transfers from other hospitals or institutions of patients in serious condition or in the last stages of a disease, as well as those patients readmitted a number of times for a disease process, are not reflected in your mortality report on them. Such patient characteristics are of tremendous significance in attempting to report results about a hospital's care and treatment.

We believe that your mortality report is flawed because it focuses on only one outcome of medical treatment and assigns an unverifiable cause of death to a final treating hospital. We look forward to helping in any way we can to have data that genuinely measures quality of care and sincerely hope this present data will be kept in perspective.

Sincerely,

John S. McDonald
Administrator



Charles Bergschneider, M.D.
Chairman, Quality Assurance Committee
Chief of Staff

PIONEER HOSPITAL

Fully Accredited by the Joint Commission on Accreditation of Hospitals



Placentia-Linda Community Hospital

October 28, 1987

Harvey Brook
HCFA
Hospital Mortality Data
6200 Security Blvd.
Meadows E Building Room 2D2
Baltimore, Maryland 21207

Dear Mr. Brook:

Thank you for this opportunity to respond to HCFA's release of selected mortality information about Medicare patients treated during 1986.

We have reviewed the data presented and have referenced each medical record for the death reported. Each death is reviewed on a monthly basis as part of our Medical Staff Quality Assurance and Peer Review Program. These cases were reviewed for appropriateness of treatment as they occurred.

A review of the current data shows that Placentia-Linda Community Hospital's mortality rates are well within the predicted ranges for each of the sixteen diagnostic categories reported.

We conducted a further in-depth review of three diagnostic categories. Our specific findings are:

Cerebrovascular Accident

The Hospital's actual mortality rate was 41%, with a range of predicted mortality rates of 11 to 52%.

A comprehensive review of the seven deaths shows that each patient had co-morbidities that contributed to their death. In addition, in six of the seven cases, both patients and/or their families had requested a "no code" (i.e., no resuscitation efforts).

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1301 Rose Drive, Placentia, California 92670-9990 (714) 993-2000

October 28, 1987
CMRI
Page Two

Severe Heart Disease

The Hospital's actual mortality rate was 47%, with a range of predicted mortality rates of 18 to 62%.

A comprehensive review of the eight deaths shows that each patient had co-morbidities, which contributed to their death, including pneumonia and pulmonary edema. In addition, in all but one case, both patient and/or their families had requested a "no code". The other patient was never fully resuscitated from an emergency room admission.

Pulmonary Disease

The Hospital's actual mortality rate was 27%, with a range of predicted mortality rates of 10 to 32%.

A comprehensive review of the fifteen deaths shows that each patient had co-morbidities that contributed to their death, including five with terminal cancer. In addition, in twelve of the fifteen cases, both patient and/or their families had requested a "no code".

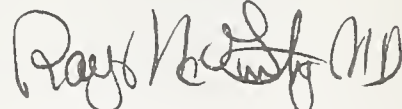
The Medical Staff of Placentia-Linda Community Hospital, as has been their practice, will continue to review all mortality cases for quality and appropriateness of care rendered to the individual patient. We were recently surveyed by physicians from the Joint Commission on Accreditation of Hospitals and the California Medical Association who stated that "this is an excellent hospital and a fine Staff, and a high quality of medical care is delivered here."

Again, thank you for the opportunity to present this response, If you or anyone receiving this information has additional questions, please do not hesitate to call.

Sincerely,


Gary G. Fybel
Administrator

/c


Ray McGinty, M.D.
Chief of Medical Staff

Through the analysis of our Quality Assurance Program, we found that approximately 50% of the deceased patients listed in the Mortality Data Release Report were in a terminal stage of their diseases upon admission; and it was the patient's or family's choice to let the disease take its course and provide only comfort in their last days. These patients and/or families had made the decision to ask that no heroics be performed to prolong the patient's life and disease process.

Again, we thank you for the opportunity to present this response to this data release. If you or anyone receiving this information has additional questions or comments, please do not hesitate to call.

Sincerely,



Mark Anonson
Executive Director



W. Raymond Menzies, MD
Chief of Staff



2309 Antonio Avenue
Camarillo CA 93010
805-484-2831

To the people of the community we serve:

Pleasant Valley Hospital is an acute care facility whose case mix includes many patients with major medical or surgical illnesses. Medicare patients comprise 33% of our inpatient admissions.

The medical staff at Pleasant Valley Hospital through our Quality Assurance program conducts a review of the medical record of every patient who expires at this facility. A full evaluation of the medical management and overall appropriateness of care is completed to assure our ongoing compliance with the highest professional standards. Mortality review is an ongoing process of the Quality Assurance program, and peer review activities are an integral part of the monitoring of the health care delivery system at this hospital. We believe that our monitoring system provides us with a continuous feedback mechanism which helps us meet or exceed quality care standards.

The hospital-specific mortality data reported by HCFA has been reviewed by hospital and medical staff. Our facility's mortality rate was within the expected range for our case mix in all categories. We welcome the opportunity to comment on this data, which provides independent confirmation of the effectiveness of our continuing efforts to provide medical care to the community we serve according to the highest professional standards.

Sincerely yours,

Norman F. Gruber
President

Gary A. Swanson, MD
President, Medical Staff

M/2

PALOMAR POMERADO HOSPITAL DISTRICT
A PUBLIC ENTITY
215 S. Hickory St., Suite 310, Escondido, California 92025

October 18, 1987

William Roper, M.D.
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
PO BOX 26684
Baltimore, Maryland 21207

Re: Planned publication of hospital mortality rates.

Dear Dr. Roper:

Thank you for the opportunity to comment on HCFA's scheduled release of hospital-specific mortality data. As the chairman of our hospital Utilization Review Committee, and a member of our medical staff with an extensive background in the fields of utilization review and quality assurance, I was asked to review the data and prepare this reply. My remarks fall into two categories: (1) General comments upon the methodology employed in collecting and presenting the data; and (2) Some specific information about our particular hospital's data that HCFA might find useful. As the mortality rates observed in our hospital were not outside the range of "predicted", I will make no effort to explain our mortality rates in any specific category.

- ◇ I am concerned about the statistical methods used to obtain "predicted mortality". Although I have no doubt that age, sex, race, being transferred from another hospital, and the simple existence of other diagnoses are factors that influence a hospital's death rate within a given disease category, I think that they are not the most important factors. I do not have the training to understand the theory underlying the statistical techniques used, and I suspect that only a handful of particularly qualified statisticians do. I have read the bibliography contained in Volume 52, No. 158 of the Federal Register, however, and cannot see that these methods

have ever been tested in a prospective fashion.

Has the following study been done? (1) Calculate the "predicted" mortality rates for the selected disease groups in a series of hospitals; (2) compare these predictions with the ensuing, actual mortality rates; and then (3) have the pertinent patient charts reviewed by experienced clinicians to see whether deviations from the "predicted" had anything to do with the quality of care delivered? If not, perhaps HCFA would like to consider using our hospital as a "beta testing site."

I think that other, much more difficult to quantitate factors are far more important. As I will demonstrate below, non-surgical deaths in our hospital result almost invariably from the nature of the illness and the ability of a patient to withstand that illness. The treatment that the patient receives has relatively little impact upon his survival. Mortality statistics for these groups of patients are fundamentally uninterpretable unless modified in some way by an index of disease severity. HCFA, of course, has acknowledged that the development of such indices is just being undertaken, and that no currently available system has been demonstrated to be sufficiently predictive of the outcome of patients' illnesses to be recommended for general use by hospitals.

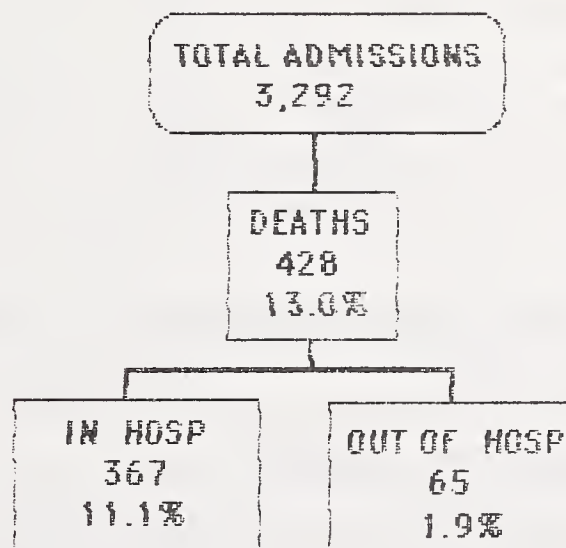
- ◇ Despite the caveat that HCFA does "not recommend the use of the information by itself to make judgements about the quality of care in an individual hospital or to make comparisons between hospitals," almost certainly newspaper readers and consumer groups will. And the sophisticated statistical "predictions," given the blessing of HCFA, lend a scientific aura to the material that makes it likely that this warning will be ignored.
- ◇ The accuracy of the data is less than perfect. The number of in-hospital Medicare deaths for our hospital was off by 14, an error rate of about 4%. The number of patients dying within 30 days of discharge should have been 61 rather than 65 (i.e. four patients said to have died after discharge actually died in the hospital), an error rate of 6%. I have no way of knowing whether additional out-of-hospital deaths occurred that weren't found. HCFA has indicated an incorrect ICD code in about 3% of the cases.
- ◇ The uninitiated reader is led to assume that the reason that the patient was admitted to the hospital (i.e. the ICD-9 code) is also the reason that the patient died. Although this is usually true, it is not true in a

significant percentage of cases (see below). When it is not, the public's perception of why patients die in hospitals is distorted.

The DRG system was devised to categorize diagnoses into groups that use similar amounts of hospital resources. A clinical-anatomic nomenclature system (the ICD code) was used as a basis, and then modified by the age of the patient, whether or not a surgical procedure was performed, and whether or not specific complications occurred. The system is reasonable enough (though far from perfect) as a way of predicting average costs; however when one attempts to derive medically relevant clinical data from it, absurdities result. I hope the modest study that I will quote below based upon our hospital's experience demonstrates this very important point.

Our hospital, Palomar Medical Center, in San Diego County in southern California, is a 275 bed, non-profit community hospital. I imagine that it is a fairly typical, medium-sized hospital. It has no medical school affiliation or teaching program. Its average length of stay for Medicare patients is typical of that observed throughout the state. The patients it serves tend to be older and perhaps a bit sicker, as this is a popular retirement area and attracts the elderly.

In 1986, according to HCFA's data, we had 3,292 Medicare admissions, with an in-hospital mortality rate of 11% (367 patients), and an additional 65 patients died within 30 days after discharge from the hospital, yielding an "overall" mortality rate of 13%. Graphically:



The mortality rate within the 16 diagnostic groupings selected by HCFA was as follows:

DIAGNOSTIC CATEGORY	CASES	% MORTALITY	
		ACTUAL	PREDICTED
EYE DISEASE	5	0	0-100
GYN DISEASE	39	0	0-66
ORTHOPEDIC DISORDERS	244	1	0-5
UROLOGIC DISEASE	153	2	1-11
LOW-RISK HEART DISEASE	237	5	2-8
GI DISEASES	297	6	3-10
SEVERE TRAUMA	117	6	4-15
METABOLIC/ELECTROLYTE DIS	89	15	7-27
GI CATASTROPHES	81	16	7-26
SEVERE CHRONIC HEART DISEASE	189	20	17-30
PULMONARY	258	22	13-26
CANCER	363	28	17-31
SEPSIS	51	31	25-54
CYAS	148	32	20-36
SEVERE ACUTE HEART DISEASE	120	43	28-48
RENAL DISEASE	22	50	11-53
SUBTOTAL	2,413	--	--
ALL CASES	3,292	13	9-16

Our results would seem to be fairly ordinary, but does this information have anything to do with quality of care in our hospital? If not, is there any reason to publish it? The upcoming HCFA release differs from the previous such releases from California's Peer Review Organization, CMRI, in that it includes the deaths occurring within 30 days after discharge. CMRI has also recently published a study indicating that a substantial number of patients dying within this period were discharged prematurely. We were uncertain whether 65 patients out of 3,292 dying within 30 days was exceptional, and consequently our Utilization Review Committee has reviewed these cases in detail. We hoped that not only would we be able to decide whether we had a problem with premature discharges, but we could review the quality of the care given in each case and relate this to HCFA's "predictions". We were able to determine the status of all 65 patients.

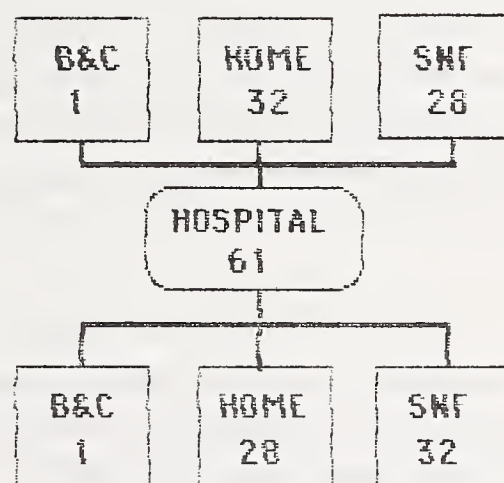
Our first question was "were any of these deaths unexpected?" If it was clear from the chart that the patient had an illness or illnesses that were

inevitably and shortly fatal, then the death was said to be expected. If the patient seemed stable, or his death was unrelated to known diagnoses, then the death was said to be unexpected. Results:

Initial total	65
Misclassified (died in hospital)	4
Expected	59
Unexpected	2
Total out of hospital deaths	61
% unexpected	3.3%

One of the two "unexpected" deaths was a patient admitted for rectal bleeding who died 23 days after discharge of an acute myocardial infarction. The second patient was admitted for coronary insufficiency, improved, then died on his 16th post-hospital day, presumably of a cardiac dysrhythmia or myocardial infarction (autopsy was not obtained). In our judgement, none of these discharges was premature, at least in the sense that the timing of the discharge adversely influenced the patient's medical outcome (we did not take such matters as patient preference or comfort into consideration).

Where were these 61 patients prior to admission and where were they when they died?



There was a net transfer of 4 of these patients from home to nursing home prior to their deaths.

Why did they die? In the table labeled Exhibit #1 (attached) we have grouped the deaths into eight broad categories that describe all of the deaths. We

have also compared the actual causes of death with the ICD code (and resultant HCFA diagnostic category) associated with their hospital admissions and noted whether the two were discordant.

The patients who died after discharge were uniformly afflicted with severe, progressive, chronic diseases. Nearly half were confined to skilled nursing facilities prior to admission to the acute care hospital. Twenty per-cent were chronically demented, a third had advanced cancer, 15% had strokes, and another 16% suffered from severe cardiopulmonary disease. In short, they were at the end of their lives and little could be done to prolong those lives. Although our physician reviewers could take issue with such minor matters as the choice of antibiotic or the dose of bronchodilator, there were no serious deficiencies in the quality of care given.

You will note that in a third of the cases the ICD code and the actual cause of death was discordant. This is an important observation that very seriously limits the interpretability of the HCFA mortality releases. The average reader will naturally assume that if a patient is admitted to a hospital with dehydration and then dies, then he died of dehydration. If patients in a hospital such as ours die at a rate of 15% in the "Metabolic and Electrolyte Disorders" category, then one might wonder if the hospital is taking unsatisfactory care of its patients.....after all, treating dehydration shouldn't be all that difficult or so frequently unsuccessful. Only those dealing with the DRG system daily understand that the DRG "principle diagnosis" represents only one, and not always the clinically most important, aspect of an individual clinical case.

Consider the following example: A 90 year old woman suffers from Alzheimer's-type dementia and resides in a skilled nursing facility. She is bed-fast, incontinent, eating poorly, and developing bed sores. She is funded by MediCal and the nursing home loses money each day that it takes care of her. She then falls out of bed, appears to be in pain, and is taken to our hospital in the middle of the night by ambulance. On arrival she appears dehydrated, but there is no obvious fracture. Her family requests that she be made a "no code." She cannot be returned to the rest home under the circumstances, but must be admitted to the hospital. Her problem is advanced age, debility, dementia, and multiple organ system failure and it is obvious that she is not going to live much longer. The real reason that she is admitted to the hospital is that the nursing facility cannot provide her the

kind of care that she needs for the amount that it is being paid and does not want her to die in their facility. There is no ICD code for "financially undesirable demented patient on the eve of death." Instead one must select some feature of her case to be the "principal diagnosis" in order for the hospital to be reimbursed by HCFA and to avoid an admission denial by the PRO. "Dehydration" is chosen. She is treated with analgesics for her pain, a day or two of intravenous fluid replacement, and then transferred to another nursing facility where she dies two weeks later. Statistically she becomes a HCFA out-of-the-hospital death in the category of Metabolic and Electrolyte Disorders. The implication to the unwary consumer of this information is that she was discharged prematurely and died of a "low risk" condition and that her condition was probably not managed skillfully.

I agree that the public has a right to know whether their local hospitals are doing a good job taking care of Medicare patients. If there is an unusually high mortality rate following a low-risk surgical procedure, then the hospital should take pains to explain this observation (or improve its performance). I do not see, however, that the mortality data about to be published serves this end. Instead, raw figures, unaccompanied by an explanation of special circumstances or conditions, are offered to an unsophisticated public, and the figures are then compared to "predicted" mortality rates. These "predictions", in turn, are based upon statistical methods using incomplete criteria that have not yet been demonstrated to have any relation to the quality of care given in hospitals. The "predictions" are given a spurious air of significance by the complexity of the computations involved, the fact that the statistical techniques are said to be "highly sophisticated", and by the fact that they have been chosen by HCFA.

My recommendations are:

- ◇ Mortality data needs to be expressed in terms of the actual causes of patients deaths rather than upon admitting ICD codes or DRG assignments.
- ◇ The DRG system should be expanded to include "social admissions", e.g. terminally ill patients, patients who cannot manage their own care and need placement in a nursing home, demented patients that have exhausted their family's ability to care for them. The framers of the DRG system have argued that these are not medical problems and that

Medicare should not have to pay for expensive hospital care for these "social admissions." I would argue that physicians often have no choice but to admit these patients to their hospitals, that this is a perfectly valid function for a community hospital, and that the cost should be borne in part by Medicare. Failure to provide DRGs for these kinds of admissions results in the arbitrary selection of some feature of a patient's case as a "principal diagnosis", which in turn debases the ICD coding system and makes DRGs an unsuitable system to use to obtain accurate clinical data.

Adding these DRGs might actually save money. These admissions could be reimbursed at a relatively low rate, as the use of hospital resources for the care of such patients should be the lowest of any admitting diagnosis.

- ◇ We should avoid using the DRG system to try to answer clinical questions, but only use it to predict hospital costs and determine hospital payments. By their very nature DRGs distort clinical data. The DRG mandated "principal diagnosis" is an artificial construct, developed for billing purposes, that often has little relevance to what is really happening to a patient, and the DRG itself is frequently unrelated to the cause of a patient's death or the source of his complications.
- ◇ If mortality data is to be published, it needs to be linked in some way to the anticipated outcome. If 50% of cancer patients died of their cancers during or shortly after admission to a hospital, this probably reflects the style in the community of taking care of terminal cancer patients rather than a deficiency in the quality of care given these patients. If a high percentage of patients die of urinary tract infections in a hospital, in all probability that hospital has had the misfortune of admitting a large number of debilitated rest home patients with catheter-related urosepsis, a condition that inherently has a high mortality rate. If 25% patients dying in the category "Electrolyte and Metabolic Disorders" had had Do Not Resuscitate orders written, then a 25% mortality rate is an expected outcome.
- ◇ HCFA needs to vigorously and speedily promote research into developing a standardized severity index, choose among the competing systems and require hospitals to grade all of their patients using this system. At present few of us are willing to invest \$50,000-150,000 up front and \$20,000-30,000 per year maintenance costs in one of the currently

available systems only to have HCFA decide to use some other system.

I am sympathetic with HCFA's position. Congress and consumers' groups are pushing for the publication of information that will help patients make intelligent decisions about where to get their medical care. However releasing raw mortality data and mortality predictions that have no validated connection with quality of care is misleading and potentially counterproductive. Hospitals that cater to patient populations with inherently high mortality rates or are located in areas where the local practice is to use the hospital as a place to die may be unfairly branded as poor care institutions. Hospitals that provide care to the affluent, where the custom is to die of terminal illness at home, may look unfairly good.

I hope these comments are helpful.

Sincerely,

A handwritten signature in dark ink, appearing to read "Lee Human MD". The signature is fluid and cursive, with the "MD" at the end being more distinct.

Lee Human, M.D.
Chairman, Utilization Review
Committee

**EXHIBIT #1: ICD-9 DIAGNOSIS VS ACTUAL CAUSE OF DEATH.
MEDICARE DEATHS WITHIN 30 DAYS OF DISCHARGE, 1986.**

	ACTUAL CAUSE OF DEATH	ICD-9 DIAGNOSIS	DISCORDANT*
	CANCER		
1	BRAIN TUMOR, WITHDREW FROM DIALYSIS	NEOPLASM BRAIN	
2	CA BREAST	CA LIVER	
3	CA ENDOMETRIUM	CA LIVER	
4	CA LUNG	MARROW NEOPLASM	
5	CA OVARY	AFTER CARE PLASTIC SURG	
6	CA OVARY	CA OVARY	
7	CA BILE DUCTS	DISORDERS BILE TRACT	+
8	CA BLADDER	CA OTHER URINARY	
9	CA CERVIX	FX LUMBAR SPINE	+
10	CA COLON	COLON CARCINOMA	
11	CA COLON	CA RECTUM	
12	CA ESOPHAGUS WITH OBSTRUCTION	CA ESOPHAGUS	
13	CA LUNG	CA LUNG	
14	CA LUNG	CA LUNG	
15	CA LUNG	CA LUNG	
16	CA LUNG	CA LUNG	
17	CA LUNG	BRAIN NEOPLASM	
18	CA LUNG	MALIGNANT NEOPLASM	
19	CA LUNG, THEOPHYLLIN TOXICITY	ANTIASTHMATICS, TOXICITY	+
20	CA PANCREAS	CA TAIL OF PANCREAS	
21	CA PANCREAS	CA TAIL OF PANCREAS	
22	LYMPHOMA	LYMPHOMA	
	DEMENTIA**		
1	FELL AT SNF. DEMENTED, BED FAST	FX DORSAL SPINE	+
2	FROM SNF, PNEUMONIA. DEMENTIA, BED FAST.	MEDICAL BACK INJURY	+
3	DEMENTIA, UROSEPSIS, SEVERE DECUBITI	UTI	+
4	FROM SNF, UROSEPSIS, DEMENTIA, BED FAST	UTI	+
5	FROM SNF. DEMENTIA, RECURRENT UTIS, BED.	UTI	+
6	DEMENTIA, SEVERE CHF, HOME	SA NODE DYSFUNCTION	+
7	FELL AT SNF, DEMENTIA, DIS FOR TERMINAL CARE	PNEUMONIA	+
8	DEMENTIA, BED FAST. BLEEDING DU.	DUODENAL ULCER	+
9	FELL IN SNF, DEHYDRATION, DEMENTIA	VOLUME DEPLETION	+
10	AGED, FAILING. HOME HEALTH CARE.	VOLUME DEPLETION	+
11	FROM SNF. DEHYDRATED, DECUBITI.	VOLUME DEPLETION	+
12	DEMENTIA, OLD CVA, COMATOSE, DEHYDRATED	VOLUME DEPLETION	+
	SEIZURE DISORDER		
1	SEIZURES, ANOXIC BRAIN DAMAGE	SEIZURES	
	CORONARY ARTERY DISEASE		
1	ACUTE MI	ESOPHAGEAL ULCER	+
2	CHEST PAIN, MI RULED OUT (AMI OUT OF HOSP)	CHEST PAIN	
3	CHEST PAIN, ASHD, COPD (CHF OUT OF HOSP)	CHEST PAIN	
4	ACUTE MI OUT OF HOSPITAL	HEMORRHAGE COMP PROC	+
5	AMI, BRAIN DAMAGE. HOME IN COMA.	MI, ANTERIOR	
6	END STAGE CARDIOMYOPATHY, DEMENTIA	HEART FAILURE	
7	END STAGE ISCHEMIC CARDIOMYOPATHY	HEART FAILURE	
8	END STAGE CARDIOMYOPATHY	HEART FAILURE	
9	END STAGE CARDIOMYOPATHY	HEART FAILURE	
10	SEVERE CHF, COPD	PNEUMONIA	+

	STROKE		
1	MASSIVE STROKE	CEREBRAL ART OCCLU	
2	SEVERE CVA	CEREBRAL ART OCCLU	
3	ISCHEMIC CARDIOMYOPATHY, CHRONIC CHF	CEREBRAL ART OCCLU	
4	MASSIVE CVA	CEREBRAL ART OCCLU	
5	SEVERE CVA	CEREBRAL ART OCCLU	
6	MASSIVE CVA	ACUTE CV DISEASE	
7	SEVERE CVA, CHF.	ACUTE CV DISEASE	
8	CVA, CA LUNG	ACUTE CV DISEASE	
9	SEVERE CVA	ACUTE CV DISEASE	
	COPD		
1	ADVANCED COPD, CHF	SUBENDOCARDIAL MI	+
2	RESP ARREST AT HOME, BRAIN DAMAGE	RESP FAILURE	
3	END STAGE COPD	COPD	
4	COPD, SEVERE CHF	COPD	
	LIVER FAILURE		
1	LIVER FAILURE, TERMINAL.	HEPATITIS	
	RENAL FAILURE		
1	WITHDREW FROM HEMODIALYSIS	CHRONIC RENAL FAILURE	
2	ESRD, GANGRENE LEG, DEMENTIA	COMPLICATION GRAFT	+
TOTAL DISCORDANT			21/61
% DISCORDANT			34.4%

Abbreviations: CA = cancer; SNF = skilled nursing facility; CHF = congestive heart failure;
COPD = chronic obstruct pulmonary disease; ESRD = end stage renal disease; UTI = urinary tract
infection. MI = myocardial infarction; AMI = acute myocardial infarction.

Disoordant: ICD code does agree with actual cause of death (see text).

Dementia*: The underlying condition leading to death was diffuse cerebral disease due to Alzheimer's
type dementia or strokes, that the dehydration, bed sore, bronchopneumonia, etc. was a terminal event

POMONA VALLEY COMMUNITY HOSPITAL

October 27, 1987

ROBERT W. BURWELL
PRESIDENT

William L. Roper, M.D.
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

POMONA VALLEY COMMUNITY HOSPITAL MEDICARE PROVIDER #050231

Dear Dr. Roper:

We appreciate the opportunity to review and respond to Health Care Financing Administration's current mortality data release, and request this letter be attached to the hospital specific information to be released in December.

**POMONA VALLEY COMMUNITY HOSPITAL:
PVCH holds reputation for handling high-risk cases.**

Pomona Valley Community Hospital is a 399-bed tertiary care hospital which maintains an unusually high level of severity in its case mix. Because of our many specialized services and unique medical staff specialists **high-risk, severely ill and terminal patients are routinely transferred to our facility for care.**

EMPHASIS ON QUALITY ASSURANCE PROGRAM AT PVCH

This facility places a top priority and heavy emphasis on its quality assurance program in order to monitor and maintain the hospital's high standards of care. Members of our Quality Assurance, Utilization Review and other appropriate medical staff committees review all mortality and significant morbidity cases. These comprehensive reviews thoroughly evaluate and scrutinize each component of medical and nursing care received by all of our patients -- not just our Medicare patients.

PEER REVIEW ORGANIZATION CITES GOOD QUALITY CARE AT PVCH

Results and effectiveness of our ongoing efforts were recently validated by a letter sent to us by the California Medical Review, Inc., your designated peer review organization in California. The letter states, **"Through analysis of data and review of Medicare discharges, no specific patterns of deficiency in the quality of care were identified for Pomona Valley Community Hospital..."**. The letter is attached for your information.



PVCH COMMENDS ULTIMATE GOAL TO MEASURE QUALITY CARE

We commend HCFA's attempt to focus attention on the measurement of quality health care. While it is difficult from a statistical standpoint to try to organize and standardize complex data infused with variables — much less be able to supply a norm that factors in severity of illness — we feel that it is important to continue fostering the need for such measurement within our present healthcare system. **PVCH has been, and intends to remain, on the forefront of quality assurance programs.**

PVCH FALLS WELL WITHIN PREDICTED RANGE

Leadership from the Medical Staff, Administration, Utilization Review/Quality Assurance, and Medical Records has reviewed HCFA's statistics involving Medicare patients treated at PVCH during 1986. We are pleased to note that for all categories, except one, **PVCH falls comfortably within its predicted percentage range of mortality in both high and low-risk categories.**

PVCH UNCOVERS DISCREPANCY IN HCFA STATISTICS

The following summarizes our subsequent findings resulting from an in-depth review of DRG 416/147 - Sepsis, in which HCFA's statistics showed a slightly higher than expected mortality rate for PVCH.

We would first like to point out that our investigation indicates a discrepancy in the statistics. While HCFA's records indicate a total of 22 patients in this category, 16 of whom expired, our records show that PVCH actually treated a total of 44 Medicare patients admitted with sepsis, 17 of whom expired. Based on this data, **PVCH does fall within the predicted range of mortality and is not an outlier in this category.** We are forwarding the appropriate information to you for verification and adjustment of your report.

REVIEW OF IDENTIFIED MORTALITIES SHOWS DEATHS NOT PREVENTABLE

Despite our discovery of the discrepancy in the statistics, we did charge a medical staff team with the task of reanalyzing previous Quality Assurance findings for the 16 patients that were identified by HCFA in this DRG category. The following was noted:

- o average age of the 16 patients was 80.75 years
- o 10 of the 16 patients were admitted from nursing homes via the Emergency Department
- o All patients were admitted with the sepsis; 10 patients were unresponsive upon admission
- o most expired of causes unrelated to sepsis

In conclusion, the reanalysis corroborates initial conclusions drawn from our routine quality assurance studies that the deaths were unfortunately not preventable. **All records indicate that appropriate medical and nursing treatment was rendered consistent with the diagnosis, and in a timely manner.**



CONCLUSION - COMMITMENT TO QUALITY ASSURANCE

As previously stated, PVCH takes the issue of quality care very seriously and intends to stay on the forefront of such efforts. Within this philosophy, we remain confident that appropriate care of the highest caliber possible is consistently delivered here at Pomona Valley Community Hospital.

Sincerely,

Robert W. Burwell,
President
Pomona Valley Community Hospital

Charles B. Chambers, M.D.
President
Pomona Valley Community Hospital
Medical Staff

CALIFORNIA MEDICAL REVIEW INC.

1388 SUTTER STREET • SUITE 1100 • SAN FRANCISCO • CALIFORNIA 94109 • (415) 923-2000

WILLIAM H. MONCRIEF, JR., M.D. *President*

JO ELLEN H. ROSS, *Chief Executive Officer*



August 3, 1987

Yvonne Anderson
Director, Utilization Review
Pomona Valley Community Hospital
1798 No. Garey Avenue
Pomona, CA 91767

SUBJECT: HCFA Identified Outliers

Dear Ms. Anderson:

During the month of March 1986, the Health Care Financing Administration (HCFA) made available a listing of statistical information on the medical care provided to Medicare beneficiaries. This listing was intended as an analytical tool for use by the Peer Review Organizations (PROs) in their review of hospital care provided to Medicare patients.

It was CMRI's responsibility to determine if a problem existed with the quality of care furnished to beneficiaries at those providers identified on the mortality outlier list and, if so, to develop a review objective to effect resolution of the problem.

Through analysis of data and review of Medicare discharges, no specific patterns of deficiency in the quality of care were identified for Pomona Valley Community Hospital. Therefore, your hospital was not included in CMRI's contracted review objectives to address this issue.

CMRI will continue to perform statistical analysis and direct review of the care provided to Medicare beneficiaries in the future.

If you have any questions regarding this information, please contact the Director at your CMRI Regional Office.

Sincerely,

Alan L. Snodgrass
Director of Review

ALSltr/jlw

RECEIVED IN U.S.

AUG 10 1987

cc: Fred Zentgraf, Project Office, HCFA Region IX
William H. Moncrief, Jr., M.D., President, CMRI
Jo Ellen H. Ross, Chief Executive Officer, CMRI



**PRESBYTERIAN
INTERCOMMUNITY
HOSPITAL**

A Regional Hospital and Health Center

*221 N. Washington Blvd.
Baltimore, Maryland 21201
LTV 1-4-87*

October 23, 1987

**William L. Roper, M.D.
Administrator
Department of Health and Human Services
Health Care Financing Administration
6325 Security Boulevard
Baltimore, MD 21207**

Dear Dr. Roper:

Thank you for allowing us to review and comment on the mortality information prior to publication. In reviewing the information, we find no errors and agree with the data as presented. It should be noted that the mortality rates for Presbyterian Intercommunity Hospital fall well below the maximum of the range in all categories while providing regional healthcare services for trauma, oncology, and cardiology.

Again, thank you for the opportunity of reviewing and commenting on the information. As with your organization, Presbyterian Intercommunity Hospital, is committed to providing the highest quality of medical care.

Sincerely,

**Richard J. Skillman
Executive Vice President**

RES:tw



Queen of Angels Medical Center

2301 Bellevue Avenue, P. O. Box 26916
Los Angeles, CA 90026, (213) 413-3000

CERTIFIED LETTER

October 22, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Re: Medicare # 050268

Dear Doctor Roper:

We have reviewed the selected mortality information which you kindly provided to us prior to its planned December publication.

We do appreciate the efforts HCFA has made in its attempt to develop factors in the model which establish certain averages. Of course, we recognize that it is not presently possible for HCFA to truly measure the severity of illness of the patients who are admitted to our hospital without clinical information.

Our hospital, as an inner city facility cares for a disproportionate share of both Medicare and MediCal patients. With many of our patients being transferred to us from nursing homes in a terminal condition. we treat a large number of severely ill individuals who are admitted with pulmonary diseases and congestive heart failure. We also operate a busy basic emergency department. These patients, whom we serve, enter our facility with comorbidities - and their average age is 70 years. Obviously, we cannot be compared to an "average" hospital with "average" patients, however, our actual mortality rate still is below the midpoint of the range of predicted mortality rates in 14 of the 16 diagnostic categories. In fact, we do not even reach the top of the range of predicted mortality rates in any category.

It is also interesting to note, that of the deaths included in your statistics, almost 20% of the patients expired after being discharged from our medical center.

Through our continuing efforts in quality assurance, departmental analysis, mortality and peer review, we do strive to provide superior care to all of our patients. The statistics which you provided which cannot measure our hospitals true performance, do at least reflect that our quality assurance program is effective. Please be assured that we will continue in our quality assurance program to demonstrate our ongoing improvements in treating the patients we serve.

Very truly yours,

A handwritten signature in cursive script, appearing to read "Richard F. Smith".

Richard F. Smith
President/CEO

RFS:jmt



QUEEN OF THE VALLEY HOSPITAL

NAPA VALLEY MEDICAL CENTER

A SISTERS OF ST. JOSEPH OF ORANGE CORPORATION

HCFN/EXEC.SEC.
1981 OCT 28 PM 3:18

Hospital - 050009

RESPONSE TO ACTUAL MORTALITY RATE: (61%)

DIAGNOSTIC CATEGORY - HS - SEVERE ACUTE HEART DISEASE

In 1986 there were 57 Medicare patients treated at Queen of the Valley Hospital for those diagnoses H.C.F.A categorized as "heart disease - severe".

Thirty-five of these patients (61% of the total) expired within 30 days of admission to this hospital.

Thirty-seven percent (37%) of the deaths were patients with cardiac arrests prior to admission to the hospital.

Ten percent (10%) suffered cardiac arrest in the emergency room or shortly after arrival due to very severe heart disease.

Twelve percent (12%) were aortic aneurysms, which is a group of patients with an extremely low survival rate.

The other mortalities in this group were people who had other severe coexisting diseases including severe stroke and neurological damage, severe chronic lung disease and severe internal bleeding.



A Catholic
Healthcare
Facility

THE MEDICAL STAFF of

Queen of the Valley Hospital

October 23, 1987

William L. Roper, M.D.
Administrator
Department of Health & Human Services
Health Care Financing Administration
Washington, D.C. 20201

RE: PROVIDER #050369

Dear Dr. Roper:

We welcome and appreciate the opportunity to submit the following statement regarding the pending public release of the Health Care Financing Administration mortality information specific to Queen of the Valley Hospital for the calendar year 1986:

GENERAL STATEMENT

Queen of the Valley Hospital is a 272 bed, general acute care hospital serving an immediate area population of approximately 500,000. Within a ten mile service area is a population of more than one million residents which have been served by such specialized hospital programs as our trauma center, paramedic base station and oncology program.

The Emergency Department of Queen of the Valley Hospital treated approximately 42,000 patients during 1986. This number of visits places Queen of the Valley Hospital as one of the three busiest private community hospital emergency departments in Los Angeles County and in the top ten for the State of California. The Hospital has also been one of Los Angeles County's twenty-three designated trauma centers for the past four years. Approximately 18% of all patients treated in the Emergency Department are admitted for hospitalization.



A Catholic
Healthcare
Facility

Queen of the Valley Hospital

William L. Roper, M.D.

October 23, 1987

Page 2

Queen of the Valley Hospital hosts a major oncology program which receives oncology patients from at least seven area hospitals for treatment. Since the program is an affiliate component of the Central Los Angeles Community Clinical Oncology Program which is funded by the National Cancer Institute, Queen of the Valley Hospital is able to offer our patients placement on national clinical research treatment protocols that would not otherwise be available to the community. The hospital has contractual relations with several health care organizations that are also Medicare providers.

The Board of Trustees, Medical Staff, Management and Hospital Staff are actively committed to rendering quality and compassionate care as we continually strive for excellence in our quality review program. Review of mortalities occurring at Queen of the Valley Hospital is an integral part of this hospital's quality review program. Although there are limitations to the data supplied by Health Care Financing Administration, Queen of the Valley Hospital supports the principle of communicating appropriate and meaningful quality of care information to consumers. Queen of the Valley Hospital welcomes the opportunity to discuss the quality of their care and services.

Evaluation of the Reported Mortality Rates

Of the seventeen Diagnostic Categories presented for evaluation, Queen of the Valley Hospital's mortality rates were within the predicted range of fifteen of the categories. The Hospital was shown to be one percent above the range of predicted mortality rates in only two areas, namely Cancer and Cerebrovascular Accidents. Since Queen of the Valley Hospital is concerned and committed to an effective quality review program an immediate re-review of the cases reported in the categories of Cancer and CVA was undertaken upon receipt of this data. The actual mortality rates of the other diagnostic categories are all within the HCFA range of predicted mortality rates and support our previous quality review findings.



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Healthcare
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Queen of the Valley Hospital

William L. Roper, M.D.
October 23, 1987
Page 3

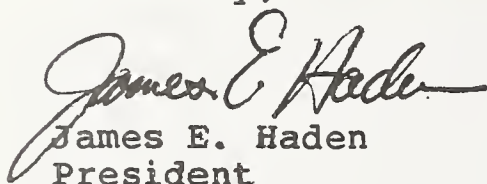
Specific Diagnostic Categories

Cancer: Ninety-four percent of the patients who expired in this category had established extensive metastasis to more than one organ system, which included lungs, brain, bone, and kidneys. A significant percentage had associated blood dyscrasias and sepsis. Twenty eight percent of the patients in this category expired after being discharged. These patients were either discharged to skilled nursing facilities or to home according to the patient or the family members request. Queen of the Valley Hospital supports an active Hospice program in addition to family support groups as part of our commitment to quality comprehensive care.

Cerebrovascular Accidents: A review of the patients included in this category disclosed that thirty-four percent of the patients expired within one or two days of admission. A significant number of the patients were "No Code", which meant that their condition was such that the patient or the patient's family had requested no resuscitation. Forty-five percent of the patients had intracerebral hemorrhages and progressive brain stem infarction was the hallmark of a significant number of the patients.

As stated previously, we appreciate the opportunity to further discuss the quality of care rendered at this facility.

Sincerely,


James E. Haden
President

JEH:EM:ac

DAVIES MEDICAL CENTER

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
P.O. Box 26684
Baltimore, Maryland 21207

RE: Provider Hospital No. 050008

Dear Dr. Roper:

Thank you for the opportunity to comment on the mortality information on Medicare patients discharged from our acute care facility in 1986.

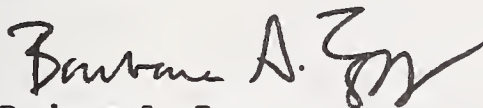
The information received has been reviewed by the Medical Chairpersons of the Utilization Review Committee and the Quality Assurance Committee as well as hospital Administration. The Medical Records Department analyzed the data to verify the accuracy of HCFA's information. The following discrepancies were noted:

1. Medicare acute discharges in 1986, according to our data, were 1382. HCFA's report noted 892 discharges for this period.
2. One patient was identified as expiring in our Skilled Nursing Facility on a date earlier than noted in the HCFA data.

The data provided by HCFA demonstrated that the patients admitted to Davies Medical Center who died within 30 days of admission had actual mortality rates which were 50% or lower in the National range of predicted mortality rates in all diagnostic categories.

Please include this letter with the publication of the mortality data for Davies Medical Center scheduled for December, 1987.

Sincerely,

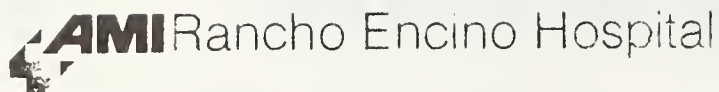


Barbara A. Zappas
Vice President for Support Services

BAZ:11

cc: Dr. G. Kardos, Chief of Staff
Dr. R. Starke, Chairman, Utilization Review Committee
Dr. J. Cullen, Chairman, Quality Assurance Committee
Greg Monardo, Executive Vice President

Castro & Duboce, San Francisco, California 94114 (415) 565-6779



October 27, 1987

William D. Roper, M.D.
Administrator
Health Care Financing Administration (HCFA)
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Dear Dr. Roper:

Thank you for this opportunity to respond to the release of data on hospital mortality rates for October 1, 1984 through September 30, 1986. Since receiving the report dated February 9, 1987, AMI Rancho Encino Hospital staff has had an opportunity to review the data.

The Director of Medical Records has validated that, with minor exceptions, the data is accurate. The Director of Hospital Quality Improvement has reviewed all cases reflected in this report.

On an on-going basis, appropriate clinical departments have always reviewed every mortality in our facility for appropriateness of care.

In regards to the Urologic Diseases category, the only category that AMI Rancho Encino Hospital is outside of the predicted range of mortality, the following should be noted:

- This particular group of patients were all over 75 years of age;
- Four of the seven patients in this group had a "no code" status. That is, an expressed wish that no aggressive action be taken should that patient's heart stop. In fact, initiating such action would be a direct violation of the patient's and family's decision.

Based on the comprehensive review of the data and the specific medical records it reflects, we are confident that you and any member of the

public who requests a copy of our statistical information will be interested in our summary report.

The Medical Staff of AMI Rancho Encino Hospital, as has been their practice, will continue to review all mortality cases for quality and appropriateness of care rendered to the individual patient. Trending analysis from these reviews is a constant endeavor to assist in identifying opportunities to improve care.

Again, thank you for the opportunity to present this response. If you or anyone receiving this information had additional questions, please do not hesitate to call.

Sincerely,



Frank Montague
Executive Director



Medicare Provider #: 050312

October 12, 1987

William Roper, M.D.
Administrator
Health Care Financing Administration
P.O. Box 26684
Baltimore, Maryland 21207

RE: MORTALITY INFORMATION ---- 1986

The following comments are provided for your disclosure with Redding Medical Center's mortality data to requesting parties.

We have had an opportunity to review the HCFA data and specific medical records of the cases included.

---Our Medical Records Director and Quality Assurance Program Coordinator has validated that, with minor exceptions, the data is accurate for those patients who expired while in the hospital.

---In conjunction with the Medical Record Department and the Quality Assurance Department, the Departments of the Medical Staff have reviewed every death case of hospitalized patients as part of their ongoing quality of care evaluations.

Through review of the HCFA data, the statistics indicate that Redding Medical Center has a death rate of 9% which is within the predicted range for hospitals with similar patient mix. The HCFA data shows that for hospitals with patients like Redding Medical Center's the mortality rate is predicted to be between 7% and 13%.

Redding Medical Center is a 174 bed acute care facility whose patient mix includes many patients with major medical and surgical illnesses. We offer services in specialty areas of cardiology, neurosurgery, orthopedic surgery, rehabilitative medicine, as well as general medicine and surgery.

The Medical Staff at Redding Medical Center conducts an intensive review of the medical record of every patient who expires at this facility regarding medical management and overall care. Mortality review is an ongoing process of the Quality Assurance Program and peer review activities are an integral part of the monitoring of the healthcare delivery system at this hospital. The Joint Commission on Accreditation of Hospitals has again granted a full accreditation which is reflective of our continuous effort and success in providing quality patient care to the community we serve.

P.O. Box 2458
1450 Liberty Street
Redding, CA 96099
(916) 243-2341

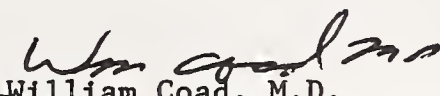
page 2
Comments on 1986 Mortality Information

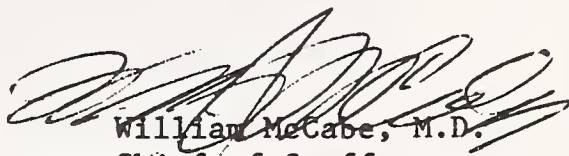
Redding Medical Center is pleased with the high level of care it is able to provide our large Medicare population.

Thank you for the opportunity to present this response. If you or anyone receiving this information has additional questions, please do not hesitate to call (916) 244 5454.

Sincerely,


Gerald E. Knepp,
Chief Executive Officer


William Coad, M.D.
Chairman, Quality Assurance Program


William McCabe, M.D.
Chief of Staff

REDLANDS COMMUNITY HOSPITAL

October 26, 1987

William L. Roper, M.D.
Adminstrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Dear Doctor Roper:

This letter is in response to HCFA's request for comment on the data report for Redlands Community Hospital (RCH) dated September 21, 1987 which covers the admission period from January 1, 1986 through December 31, 1986.

Our medical record and utilization review departments have conducted comprehensive reviews of this data and corresponding medical records in the category where the RCH mortality rate is higher than HCFA's predicted range of mortality. The following are specific comments on these findings which will allow more accurate interpretation of our hospital's data for HCFA and others who are interested in information about Redlands Community Hospital.

HCFA's model categorizes deaths within 30 days of admission as they relate to a principal admitting diagnosis. However, patient deaths are often due to other conditions besides the principle diagnosis for which they were admitted. The HCFA statistics included a number of deaths that occurred for reasons other than that for which they were admitted to Redlands Community Hospital. (For more specific analyses of the HCFA model, please see the attachment.)

An example of inconsistencies that result from HCFA's attempting to relate the principal admitting diagnosis with the reason for death is evident in the one RCH mortality rate which exceeded HCFA's predicted range of mortality. The following are some of the deaths that were classified in the pulmonary disease category. In 23 of the cases we reviewed there were other diseases which were major contributors to the cause of death as shown below:

In twelve (12) deaths the patients also had significant cardiac disease,
In five (5) deaths the patients also had significant renal failure,
In three (3) deaths the patients also had significant Alzheimer's disease,
In three (3) deaths the patients also had significant gastrointestinal disease, and other significant reasons for deaths ranging from leukemia to multiple sclerosis.

The above information reveals the limitation of the HCFA model in the pulmonary disease category and it may be similarly limited to other diagnostic categories.

CA 374

350 Terracina Boulevard, P.O. Box 3391
Redlands, California 92373-0742
(714) 793-3101, Telefax (714) 793-2167



In summary, Redlands Community Hospital does not believe these statistics accurately reflect the quality and appropriateness of medical care. We have in place a comprehensive program which reviews appropriateness of care on a routine and systematic basis utilizing a team which includes Medical Staff, Nursing and management personnel. All patient deaths are reviewed for appropriateness of care on a case by case basis. The reason for deaths in the pulmonary disease category has low correlation with the principal admitting diagnosis and the HCFA model is unable to correct for the multiple factors that influence the risk of death such as severity of illness and the patient's previous health status.

We appreciate this opportunity to respond to your findings and invite you or any member of the public receiving this material to call me at (714) 793-3101 if I may answer additional questions.

Sincerely,

A handwritten signature in cursive script, appearing to read "Gary Cottongim".

Gary Cottongim
President

Attachment (1)

American Hospital Association



Capitol Place, Building #3
50 F Street, N.W.
Suite 1100
Washington, D.C. 20001
Telephone 202.638-1100
Cable Address: Amerhosp

September 14, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Hubert H. Humphrey Building
Room 314-G
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Dr. Roper

On behalf of its nearly 6,000 hospital members, the American Hospital Association welcomes this opportunity to comment on the recent notice announcing the Health Care Financing Administration's intention to publish hospital mortality statistics (HSQ-148-GNC).

This is clearly an issue of vital importance to hospitals that we believe should be approached with the utmost care. The damage that could be done by the inadvertent release of incorrect or misleading data should not be underestimated. The AHA appreciates HCFA's attempts to create a more open and orderly process for the release of this information than was used last year. The publication of this notice in the Federal Register discussing the plans for disclosure of hospital statistics, as well as the observance of a 30-day hospital comment period on the data themselves, are positive steps. In addition, HCFA has taken unusual pains to solicit the advice of interested parties on earlier proposals for the information disclosure, and we are pleased to see that several of our suggestions about how to display the information have been adopted. Nevertheless, the AHA continues to have serious reservations about the publication of these hospital mortality statistics for three reasons:

1. The specific analytic methods used to generate the statistics have changed over the past two months as the policy decision over exactly what to release has evolved. Although the published notice provides a good framework for understanding the essential character of the analysis, it is important that complete information be made available as soon as possible so that hospitals and the general public will have all the information necessary to understand fully the nature of analysis and the implications of the statistics.

2. From what we have been able to understand from our technical discussions to clarify the information provided in the notice, some of the technical decisions made to generate the information will tend to overstate the confidence that the public should have in the predicted mortality rates. Specifically, implicit in your statistical methods is the assumption that the predicted mortality rates should be taken as normative. Consequently, users of the data may conclude that quality problems exist where, in fact, they do not, or vice-versa.
3. Although it may not have been intended, the description of the model may be read by the public as implying that the publication of hospital mortality statistics will provide a consumer guide to hospital performance when, in fact, it has never been established that the statistical analysis provides a valid indicator of hospital quality.

Our comments on the planned publication of hospital data fall into two general categories: first, the conceptual issue of whether mortality can provide a guide to hospital quality; second, more technical issues regarding the particular statistical methods used.

The relationship between mortality and hospital performance

According to the notice, HCFA intends the information to be used by consumers in making decisions about their health care; placed in this context, the statement, deep within the notice, that the differences between actual and expected mortality rates do not necessarily reflect especially high or low quality care loses its impact. If it is true that the results of the statistical analysis may result from failures of the model, then it is inappropriate to present the information as if it can serve as a hospital quality index for consumer use. The statistical analysis is not capable of definitively attributing the death to the care provided by the hospital and should not be presented as if it does.

As we noted in our August 25 letter to your office, it is essential that HCFA preface the publication of the data with a frank discussion of both the statistical and conceptual limits of the model for making inferences about hospital quality in language that can be understood by the general public. In addition, HCFA should lay out a plan to validate the relationship between the statistical results and hospital quality. According to the notice, HCFA intends to continue to refine the statistical model but HCFA has nowhere committed itself to undertaking the necessary validation study to determine whether this statistical approach to comparing mortality rates really reveals anything about hospital performance.

We understand that HCFA faces strong pressures to publish some information that may be indicative of hospital quality. To realize the full value of this sort of data disclosure, it is essential to determine whether the results of the analysis are meaningful. It is particularly important for HCFA to state that the statistics will be useful primarily to hospitals themselves and to Peer Review Organizations, by giving them some suggestions of where to focus their review. The data should certainly not be used alone in making plans for

hospital care or deciding which hospital to use. It is essential that HCFA provide the consumer with guidance on how to use the statistics, rather than simply warning them of the possibility of error.

The analytic method

The AHA appreciates the efforts that have been made to supplement the published information with more of the technical detail both in writing and in telephone conversation. However, a more complete description of the methods used to produce the data to be released will be necessary if hospitals or the public are to correctly interpret the published data. In particular, it is important to see the definitions of the variables used in the model and the diagnostic statistics needed to evaluate independently the reliability of the model's predictions.

We hope that these gaps in the published information will be filled well in advance of the release of the mortality data to the public. You have no doubt noted that the complexity of the statistical calculations is such that considerable time is needed by even the statistically adept to understand what was done and the reasons underlying the many choices that went into the analysis. In our discussions with HCFA staff, it has become apparent that the final analysis differs somewhat from what was described in the notice. For this reason, it is important that a complete description be made available to the public as soon as possible.

Several of the methodological choices made in constructing the analysis may tend to underestimate the hospital's "predicted" mortality rate, which, when compared with the actual mortality rate, would place the hospital under unwarranted suspicion of poor quality care when, in fact, the difference may be due to the inability of the model to predict mortality accurately. In order to explain why we think this is true, we have to resort to a somewhat technical discussion, for which we apologize. We nevertheless believe that these technical issues are directly relevant to an understanding of the analysis and to accurate public perceptions of what the analytic results actually show.

The methodological choices made in constructing the analysis obviously reflect critical policy decisions. Those decisions in turn reflect the meaning that the Department intends hospitals and the public to attach to the published data. As we understand it, the following data will be released:

- o the total number of Medicare patients admitted to the hospital during 1986;
- o the hospital's actual mortality rate, computed by dividing the number of patients who died within 30 days of admission by the total number of admissions; and
- o the range (referred to in the notice as the "95 percent prediction interval") of the predicted mortality rate.

From the perspective of the hospital manager, or the member of the lay public, the prediction interval is very likely to be construed as an estimate of what the hospital's mortality rate should be if its patients received "average" care. By referring to the model as providing measures of performance, HCFA encourages the public to attach a normative significance to the predicted mortality rate. Furthermore, the method used by HCFA to construct the "95 percent prediction interval" assumes that the predicted mortality rate is an estimate of what the hospital's mortality rate would be if its patients received average care. Specifically, the prediction interval that we understand you are proposing to use is simply the binomial confidence interval for a sample of size n with a mean probability of death equal to the predicted mortality rate. Put in English, the correct interpretation of the prediction interval for the predicted mortality rate as you have computed it is as follows: "assuming that the predicted mortality rate is the actual risk of dying if the patients admitted to the hospital received average care, then the observed mortality rate (or alternatively, the number of patients who would die) would be between X and Y 95 percent of the time." In adopting this method, HCFA assumes that there has been no error in the prediction of the hospital's mortality rate, and that the only source of error is chance. No allowance is made for the possibility that the prediction may be in error. Thus, the "prediction interval" to be published is, from the perspective of the intended user, who is most interested in the reliability of the prediction, not pertinent.

Rather, the interval of interest to the intended user concerns the reliability of the prediction itself, particularly as the models you are using have an apparently low predictive power. We understand that there are two reasons that HCFA has chosen not to include in the calculation of the prediction interval the uncertainty of the prediction itself. The first was that the variance of the predicted mortality rate was dominated by the "binomial variance"; thus, the contribution of the unexplained variance in the regression model could be ignored. Our own analysis of this issue suggests otherwise. The second was that the unexplained variance reflected quality of care and so should be ignored. However, the unexplained variance also reflects patient characteristics that should not be ignored. By ignoring that term, particularly in the absence of any real validation of the model, you are implicitly telling the user that the model's predictions should be taken as normative. AHA recommends that you reconsider your decision and recompute the prediction intervals to reflect both the inherent uncertainty that would exist even with perfect knowledge of what the hospital's mortality rate should be, and the additional uncertainty produced by the limitations on the explanatory power of the models.

Two observations made during our technical discussions suggest that the methods used may overstate the confidence the public should place in the analytic results. The first observation was that taking into consideration the unexplained variance increased the estimated error of the prediction, and

hence the prediction interval, up to a factor of two. The second observation was that using bootstrapping to empirically simulate the confidence interval yielded a substantially wider confidence interval than was obtained using the binomial variance of the predicted mortality rate. Although these remarks may have been taken out of context, they do suggest that further review of the method is in order. The fact that the remarks may have been taken out of context also underscores the importance of making available a complete technical description of the model and the results of the empirical work used in developing your proposed method.

The main question is whether the model has adequately identified and measured all the patient characteristics that can affect the hospital's death rate. Clearly, many factors may affect the hospital's death rate, the chief of which is how ill its patients are. Severity of illness is one factor that the model, by HCFA's admission, does not take into account. Other factors can also contribute to the probability of death and are equally difficult to measure and control for, for example, the patient's health status, the patient's psychological condition, and family support. In the absence of complete measurement of the factors affecting mortality, any deviation from the "predicted" mortality rate may be due to unmeasured differences in patient condition or differences in the quality of care provided by the institution. The deviation itself is not an index of quality. The real validity issue concerns the extent to which deviations are attributable to the quality of patient treatment.

The cross validation performed as a check on the model's predictions, while interesting, does not really address the question of whether the predictions are, in fact, valid. The reason is simple. Given the extremely large sample, it is not surprising that estimates of the estimated parameters and predictions derived using one half of the data would agree closely with the estimated parameters and predictions derived using the other half. This agreement says more about the representativeness of the data than the reliability of the model. Of greater interest would be the stability of the model's predictions given different approaches to describing the clinical condition of patients, e.g., differing diagnostic classifications. The question of interest to hospitals and to the public is whether different ways of describing the clinical condition of patients result in different predictions of mortality.

Conclusion

It is evident that the analytical method used to generate the comparative hospital mortality statistics leaves open the central question: are the differences in hospital mortality rates a reflection of differences in their patient load, or can they be attributed to the hospital treatment? This is a mystery that the analysis may eventually help to unravel, but does not presently solve.

In view of this, HCFA should caution readers that these data do not provide an index to hospital performance. The final publication of the data ought to be accompanied by a statement on the proper use and limits of the analysis to provide some guidance to beneficiaries in interpreting and using the data. In addition, HCFA should begin to validate the relationship between the analytic results and hospital quality by requiring Peer Review Organizations to compare the results with an in-depth medical record review.

Third, HCFA should release all of the technical analyses that supported the development of the model. A complete description of the model and the statistical methods used to estimate it, together with complete information needed to evaluate the model's reliability, should be released at the same time that the data are released to the hospitals for review. As is evident from the discussion above, the statistical methods used to produce the estimates are extremely complex. AHA, its member hospitals, and members of the public need sufficient time to familiarize themselves with the technical details of your methods and policy choices if they are to respond appropriately when the results of applying your methods are released to the public later this year. Providing this information should not be delayed until the data are released to the public.

Finally, it would be greatly appreciated by the hospitals of this country if HCFA would provide them with advance notice of the actual date for release of the data to the public. Individual hospital notice would not be necessary, but a notice published in the Federal Register giving the date on which the data will be released would provide hospitals with some "advance warning" of calls from the press and public concerning the data.

If you have any questions about these comments, please contact Jim Marrinan in this office (202) 638-1100 or Henry Bachofer in our Chicago office (312) 280-6599.

Sincerely,



Jack W. Owen
Executive Vice-President
American Hospital Association

cc: Thomas G. Morford, Director
Health Standards and Quality Bureau

HSQ-148-GNC
P.O. Box 26676



REDWOOD MEMORIAL HOSPITAL

A Sisters of St. Joseph of Orange Corporation

October 26, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Dear Colleague:

Thank you for the opportunity to provide input on the mortality statistics for Medicare patients treated in 1986.

Redwood Memorial Hospital is a 47-bed acute care hospital located in a rural setting whose case mix includes patients with major medical and surgical illnesses. Our range of services includes orthopedic services; general surgery services; urology; pediatrics; obstetrics and gynecology; family practice; ear, nose, and throat specialties; internal medicine; radiology; and 24 hour basic emergency services.

As a JCAH accredited facility, the medical staff at Redwood Memorial Hospital conducts intensive reviews on every patient who expires regarding their medical management and hospital care. This mortality review is part of the hospital's ongoing quality assurance program.

Redwood Memorial Hospital mortality data reported by Health Care Financing Administration (HCFA) has been reviewed by: hospital administration, president of the medical staff, quality assurance committee, director of medical records, and utilization review. Overall, our data seems to be within the range of predicted, with only one category (severe chronic heart disease) creeping over by one percent.

Thank you for the opportunity to respond.

Sincerely,

Willard G. Foote
President/C.E.O.

James Russell, M.D.
Medical Staff President



Growing With Our Community

October 26, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

The 30-day mortality rates as released by the Health Care Financing Administration (HCFA) for the 10 high-risk and the 6 low-risk diagnostic categories of Medicare patients admitted to Riverside Community Hospital during 1986 were reviewed.

Riverside Community Hospital's actual mortality rates fall within the ranges of HCFA predicted mortality rates for all 16 categories.

Although Riverside Community Hospital's actual mortality rates fall within expected ranges, the following comments should be considered when utilizing this data in any manner to indicate quality of care.

--Quality judgements can only be made after review of the information contained in the patient's medical record

--The results of treatment are likely to be influenced by more than those factors taken into account by the HCFA analysis. Additional factors not taken into account in the statistical analysis are severity (seriousness) of the illness, the stage to which the illness has advanced, the general health status of the patient and support elements available to the patient which include psychological, social, economic and environmental factors.

--The patient population which comprised these mortality data was limited to those patients whose last admission was to our hospital and who died. It does not count inpatient deaths that occurred more than 30 days after admission and it counts deaths that occurred after discharge but within 30 days of admission.

--Statistical analyses of mortality rates can only point out areas for further review. It is not an indicator of quality.

On an ongoing basis the Medical Staff at Riverside Community Hospital reviews mortalities. This review is just one facet of the quality assurance program at the hospital. Attention is paid to the timeliness and accuracy of diagnoses, complications, appropriateness and necessity of laboratory and x-ray testing and necessity for admission.

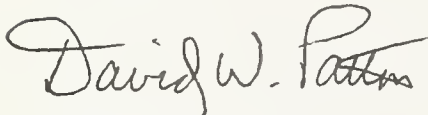
Riverside Community Hospital subscribes to HCFA's plan to educate the public by

Affiliated with Community Health Corporation

4445 Magnolia Avenue, Riverside, CA 92501, Telephone 714-788-3000

publishing morality rates as one important aspect to assist in the evaluation of the quality of care in an institution, but cautions that additional information relating to severity of the disease is necessary before an intelligent informed decision can be made. We will continue to utilize and expand our quality assurance program, to monitor and review hospital mortality as one aspect of that program, and to strive to provide the optimum quality of care for the patients that we serve.

Sincerely,

A handwritten signature in cursive script that reads "David W. Patton". The signature is fluid and somewhat stylized, with the first and last names being more prominent than the middle initial.

David W. Patton
President

bjo



RIVERSIDE GENERAL HOSPITAL
University Medical Center
A Teaching Hospital
9851 Magnolia Avenue
Riverside, California 92503
(714) 351-7116

50 YEAR MEMBER AMERICAN HOSPITAL ASSOCIATION

OFFICE OF THE ADMINISTRATOR

October 21, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21208

RE: **RGH-UMC MORTALITY INFORMATION**

Gentlemen:

Thank you for the opportunity to respond to the release of data by HCFA on the Hospital mortality rates for the calendar year 1986 at Riverside General Hospital-University Medical Center. The Medical Staff, the Department of Quality Assurance, Patient Care Review Committee, as well as, the Departments of Medicine, Surgery, Psychiatry, Pediatrics, and Obstetrics and Gynecology have reviewed all charts of patients who have expired at this Hospital.

These charts are reviewed as part of the ongoing quality assurance program at the Hospital. In reviewing the mortality data released by HCFA, we would like to direct your attention to the mortality described under cerebral vascular accidents. These charts were again reviewed by the appropriate departments and in each and every case the treatment appeared to be appropriate, confirming our ongoing observations for quality of care at Riverside General Hospital. California Medical Review Incorporated has done an analysis of data and review of Medicare discharges and found no specific patterns of deficiency in the quality of care at Riverside General Hospital- University Medical Center.

In accumulating the huge amount of data collected by HCFA from billing forms, discrepancies in the categorization data do occur. We have identified patients categorized as dying of stroke in our series of cases that died of other causes. In addition, we have identified substantial additional Medicare patients admitted to the Hospital with strokes who were not included in the calculations. When these factors are taken into consideration our mortality rate falls well within the national average. The criteria for admission to our Hospital are strict so that only patients with significant severity of illness are admitted. If admission criteria were more relaxed, the result in terms of death rate would be much less.

Established in 1893
A Department of the County of Riverside, A Public Entity
Accredited by the Joint Commission on Accreditation of Hospitals

Riverside General Hospital-University Medical Center is a public hospital. Persons coming for care frequently have limited resources. They put off treatment until advanced disease finally forces them to seek care. Severity of illness statistics reveal that these patients have a significantly greater severity of illness than in other non-public hospitals. Based on these considerations it becomes clear that the death rate reported by HCFA requires closer analysis before conclusions on the quality of care can be reached.

Sincerely yours,

A handwritten signature in cursive script that reads "Dale B. Sparks, M.D.".

Dale B. Sparks, M.D.
Chief of Medical Staff
Riverside General Hospital-UMC

DBS:er



Ross General Hospital

1150 Sir Francis Drake Boulevard
Post Office Box 857
Ross, CA 94957
Telephone: (415) 455-7800

October 23, 1987

William L. Roper, Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for the opportunity to respond to the data provided on our hospital's mortality statistics for the period January 1, 1986 through December 31, 1986.

Ross General Hospital is a 193 bed acute care facility, located in Marin County, which provides general medical, surgical, chemical dependency, psychiatric, and skilled nursing services to a large, predominantly Medicare population.

The hospital specific mortality data reported by HCFA has been carefully reviewed by the Hospital Administrator, the Chief of Staff, the Quality Assurance/Utilization Management Physician Advisor, the Director of Medical Services, and the Utilization Management Coordinator and Analyst.

The Medical Record Department Coordinator has validated that with minor exceptions, the data is accurate. Please see the attached revisions resulting from our evaluation of the data. Even with these changes, there were no diagnostic categories in which the actual mortality rate was outside the range of the predicted mortality rate. These statistics in conjunction with our review of the mortality cases, suggest that our facility does provide a high quality of care.

The Medical Staff at Ross conducts an extensive review of every patient who expires at our facility for overall quality of care. Mortality review is an ongoing process of our Quality Assurance Program, and peer review activities are an integral part of the monitoring of the healthcare delivery system at Ross. We believe that our review process provides a continuous feedback mechanism that allows us to meet and exceed quality of care standards.

Page 2

Again, thank you for allowing us to respond to the HCFA mortality statistics for our hospital.

Sincerely,

Roger W Moore

Roger W. Moore
Administrator
Ross General Hospital
Provider Number 05-0134

John D. Dooley, M.D.
John D. Dooley, M.D.
Chief of Staff

HOSPITAL - 050134

ROSS GEN HOSP

ROSS CA

DIAGNOSTIC CATEGORY	CASES	ACTUAL MORTALITY RATE	RANGE OF PREDICTED MORTALITY RATES
ALL CAUSES	669	12 %	9 TO 16 %
CA - CANCER	43	21 %	10 TO 36 %
CE - CEREBROVASCULAR ACCIDENTS	91	23 %	17 TO 50 %
EY - OPHTHALMOLOGIC DISEASE	4	0 %	0 TO 100 %
GC - GASTROINTESTINAL CATASTROPHES	19	21 %	5 TO 41 %
GI - GASTROINTESTINAL DISEASE	54	2 %	2 TO 16 %
QU - UROLOGIC DISEASE	11	0 %	0 TO 45 %
OY - GYNECOLOGIC DISEASE	3	0 %	0 TO 100 %
HL - LOW-RISK HEART DISEASE	22	14 %	1 TO 27 %
HM - SEVERE CHRONIC HEART DISEASE	27	11 %	11 TO 43 %
HS - SEVERE ACUTE HEART DISEASE	26	46 %	25 TO 62 %
ME - METABOLIC/ELECTROLYTE DISTURBANCES	16	19 %	6 TO 46 %
OP - ORTHOPEDIC DISORDERS	59	0 %	0 TO 12 %
PN - PULMONARY DISEASE	47	36 %	11 TO 36 %
RN - RENAL DISEASE	8	33 %	2 TO 63 %
SE - SEPSIS	7	71 %	15 TO 79 %
TR - SEVERE TRAUMA	33	9 %	3 TO 25 %



Sacred Heart Hospital

October 23, 1987

William L. Roper, M. D.
Administrator
Health Care Financing Administration
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

We appreciate opportunity to comment on the Medicare patients who were treated in our hospital during 1986. We have reviewed the information which was enclosed and wish to provide the following comments:

- . mortality review is an activity which has been performed for a number of years and is an integral part of our medical staff activities.
- . we do support the principle of communicating appropriate and meaningful quality of care information to people who utilize our hospital.
- . our internal review identified one diagnostic category which produced some concern -- cerebral vascular accidents. The predicted range of mortality rates was from 16-60%, our actual mortality rate was slightly above the upper range. In reviewing those cases we wish to provide two observations:

1. the total number of cases was 16 which raises issues of sample size
2. the age range of the patients who died was from 59 to 92 with 82% of the cases being over 75 years of age. Given the diagnostic category and the ages of the patients we wonder about the statistical validity given the small numbers.

Once again we appreciate the opportunity to provide comments on the 1986 mortality data. Should you have any questions or need clarification regarding our comments, please feel free to contact me at (209) 583-2100.

Sincerely yours,

M. Michael Arishita

M. Michael Arishita
President/CEO

MMA/cks

Conducted by the
Sisters of the Third Order of St. Dominic, Inc.

1025 North Douty Street
Hanford, California 93230
(209) 582-2551

CA 385

SADDLEBACK COMMUNITY HOSPITAL

24451 Health Center Drive
Laguna Hills,
California 92653
(714) 837-4500



October 8, 1987

William Roper, M.D.
Administrator
Health Care Financing Administration
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Saddleback Hospital and Health Center would like to take this opportunity to respond to the Health Care Financing Administration current release of data on hospital mortality rates.

We feel that anyone looking at this type of information needs to realize that each patient and hospital are different. There are a variety of reasons that a hospital's mortality rate may vary from the average:

The hospital may treat a much older patient population than other hospitals.

More of the hospital's patients may be admitted for complex or high-technology care such as open heart surgery or complex cancer care where chances of survival are reduced.

A high percentage of a hospital's patients may be admitted through the emergency department. Typically, these patients are much sicker when they are admitted to the hospital and again, mortality rates may be higher.

Statistically, a single death of a very ill patient in a small sample can easily skew a hospital's mortality rate.

The important thing to remember is that mortality rates do not indicate why a patient died. A statistical system, no matter how complex, cannot measure the quality of care provided by a hospital. Quality judgments can only be made on the basis of review of medical charts. At Saddleback Hospital and Health Center, all patient deaths are reviewed by physician committees to determine if anything could have been done to improve the care of the patient. This is part of our ongoing Quality Assurance Program which has been in effect for some time.

Saddleback Hospital and Health Center has always endeavored to provide quality patient care, and will continue to do so in the future. If you or anyone receiving this material have additional questions, please do not hesitate to call me at (714) 770-3623.

Sincerely,

James L. Ray
Executive Vice President

Your Center for Health Care ExcellenceSM

CA 386



2101 North Waterman Avenue

San Bernardino, California 92404-4836 • (714) 883-8711

October 21, 1987

William L. Roper, M.D., Administrator
HCFA - Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Dear Dr. Roper:

Thank you for the opportunity to respond to the mortality statistics for calendar year 1986 prior to public disclosure. Our Quality Assurance Committee Chairman, Medical Records Director and Quality Assurance Director have reviewed the report and find that the majority of the data is accurate, however, it does not take into consideration the entire Medicare population treated at the hospital. In addition, two of the patients listed were not our patients and 59 expired elsewhere.

St. Bernardine is a 311 bed nonprofit acute care facility that is part of the Sisters of Charity of the Incarnate Word Health Care System. Our patient population includes many people with serious medical and surgical illnesses. We are a full-service medical center whose mission is to offer care to all people in need, with an emphasis on the indigent and elderly. A large number of seriously ill patients and people whose conditions require continuous care, both inpatient and out, are attracted to our facility by the specialty care offered in the area of cardiovascular and gastrointestinal illnesses.

In addition, the expertise found in our medical staff and the advanced technologies available in our hospital combine to make us a major referral center for this region. Examples of the technology available include Magnetic Resonance Imaging, Cancer Treatments, Angiography and Angioplasty (adult and child).

As a nonprofit health care provider, our mission is to offer an environment of hope, healing and peace to all who seek relief in times of birth, sickness, and death. Programs, such as Hospice, that concentrate on the quality of death, exist and thrive at St. Bernardine Medical Center.

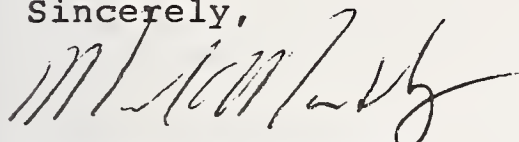
Formerly St. Bernardine Hospital

HCFA-Health Standards & Quality Bureau
Hospital Mortality Information
October 21, 1987

The medical staff Quality Assurance Program at St. Bernardine Medical Center reviews all mortality cases for appropriateness of care. Quality assurance and medical staff peer review activities are an integral part of monitoring the health care delivery system at this hospital.

The differences in mortality rates between hospitals should not be interpreted as differences in the quality of care. Our Medical Center plans to incorporate data from this report into our ongoing quality assurance and utilization Management program as one of many elements reviewed to maintain and improve the quality of care rendered.

Sincerely,



Michael E. Markley
Administrator

MEM/nd

cc: Richard Allen
Ruth Barker
Brigid Connell
Shelby K. Jernigan, M.D.
Thelma Z. Korpman, M.D.



ST. JUDE HOSPITAL AND REHABILITATION CENTER

A Sisters of St. Joseph of Orange Corporation

101 East Valencia Mesa Drive, Post Office Box 4138,
Fullerton, California 92634 Telephone (714) 871-3280

Paul S. Viviano, President

October 21, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Doctor Roper:

Thank you for this opportunity to respond to the release of data on hospital mortality rates for Calendar Year 1986. The Director of Medical Records has validated the data, with the following exceptions:

- 215 deaths were verified.
- 42 reported patients were treated and discharged in stable condition for continued care at lower levels of care.
- 2 patients were treated, stabilized and transferred to other acute care facilities.

The hospital specific mortality data reported by HCFA has been carefully reviewed by the Chief of the Medical Staff, Physician Chairman of the Utilization Review Committee, Chairman and Director for Quality Assurance, DRG Coordinator and Director of Medical Records. On an on-going basis, appropriate clinical departments have and will continue to review every mortality within our facility for appropriateness of care.

Based on comprehensive review of the data and the specific medical records it reflects, we are confident that you, as well as our community, will be interested in our summary report.

It is noted that our overall mortality rate of 11% fell easily within the predicted range of 9% to 15%. St. Jude Hospital and Rehabilitation Center is a 310-bed acute care facility whose case mix includes many elderly patients with major medical and surgical

illnesses. We are a full service medical center and specialize in many areas. Our Oncology program maintains a full accreditation by the American College of Surgeons Commission on Cancer and is affiliated with USC's Cancer Management Network. We provide the latest in medical technology in the treatment of our Oncology patients. Our Cardiology and Open Heart Surgery Program is one of the largest in Orange County performing more than 200 coronary bypass surgeries and valve surgeries each year. Construction is expected to be completed soon for our second state-of-the-art Heart Catheterization Lab. St. Jude Hospital and Rehabilitation Center also boasts a 50-bed Neurological Rehabilitation Center focusing on Stroke, Spinal Cord Injury and Brain Injury patients. The Case Mix Index for St. Jude Hospital for this period was 1.4.

The following summarized our findings by the significant Diagnostic Category:

CA - CANCER

The predicted percentage of deaths in this category was 17% to 34%. Our actual was reported at 22%.

It should be noted that:

- The number of deaths in this category represents one of the major service centers of our facility - Oncology.
- All patients who expired were diagnosed as having Cancer with metastasis and/or other organ failure at the time of admission.
- The majority of the patients and/or their families had requested "No Code".

CE - CEREBROVASCULAR ACCIDENTS

The predicted percentage of deaths in this category was 20% to 41%. Our actual was reported at 37%.

Of the patients in this category who expired, it should be noted that:

- One patient was discharged home with family, assisted by Home Health Care.
- One patient, because of religious affiliation, refused treatment here and was transferred safely to another facility of the patient's choice.
- Two patients were discharged to Skilled Nursing Facilities for terminal care. Their deaths were not unexpected, but they no longer required acute care. Both of these patients were discharged in stable condition.

- Thirteen of the remaining 27 deaths, because of the gravity of their stroke, were classified "No Code" soon after admission or were removed from life support by family request.
- The remaining deaths were found to be non-preventable and results from a growing elderly population within our community.

RN - RENAL DISEASE

The predicted percentage of deaths in this category ranged from 6% to 51%. Our actual was reported at 44%.

It should be noted that:

- This represents 7 deaths for the 12-month period.
- 6 of the 7 patients were in the final stages of their illness and were classified "No Code" by family request.
- The remaining patient presented in cardiac arrest to the Emergency Department; was successfully resuscitated, but despite aggressive critical care efforts, succumbed to his disease three days later.

SE - SEPSIS (OVERWHELMING INFECTION)

The predicted percentage of deaths in this category ranged from 18% to 55%. Our actual was reported at 37%.

- One patient was admitted and treated for a home-acquired infection of his feeding tube site. The patient showed improvement with treatment and was able to be discharged home. His death occurred two weeks later at home.
- One patient was presented to the hospital with a signed Living Will in which he requested no "aggressive" care be given. He was given supportive care and was allowed to die as a natural course of his disease.
- Seven patients were admitted in Septic Shock from home or Skilled Nursing Facilities. Despite aggressive attempts to reverse the infection, they died as a result of their advanced condition.

ME - METABOLIC/ELECTROLYTE DISTURBANCES

The predicted percentage of deaths in this category was reported to be 14% to 41%. Our actual was reported at 34%.

William L. Roper, M.D.
October 21, 1987
Page Four

It should be noted that:

- This reported actual percentage represents 18 deaths. However, 5 of these 18 patients were discharged in stable condition and died a minimum of 9 days later.
- Seven of the remaining 13 patients had diagnoses of Cancer with metastasis. All of the patients had developed profound dehydration as a result of weakness, chemotherapy, radiation therapy or an inability to eat or drink.
- Two patients were admitted with pneumonia and dehydration. Both patients were treated aggressively but were unable to be stabilized.

As you stressed in your letter to us, mortality alone cannot and should not be considered as a complete measure of the quality of care of a given hospital; but instead, merely presents a starting point with which to look at other very complex issues such as severity of illness, co-existing conditions, and other pertinent medical data.

Commensurate with our philosophy and commitment to excellence, we, in conjunction with our Medical Staff, will continue to review each hospital mortality for quality of care rendered. We believe that our quality assurance program provides us with a continuous feedback mechanism in an effort to continue to meet and exceed quality care standards.

Thank you for the opportunity to present this response.

Sincerely,

Paul S. Viviano

Paul S. Viviano
President

PSV/cr
31/24

c: Mr. Edward D. Goldstein, Chairman, Board of Trustees
C.M.R.I.
California Hospital Association
Senator Pete Wilson (R), California State Senate
Senator Alan Cranston (D), California State Senate
Representative William Dannemeyer (R), District #39



**Samuel
Merritt
Hospital**

Medicare Provider #: 050043

October 23, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear William L. Roper, M.D.:

Thank you for giving us the opportunity to provide input on the analysis of HCFA's patient mortality data. Samuel Merritt Hospital fully supports public availability of this information for the education of health care consumers.

Samuel Merritt Hospital is a 364 bed acute care facility, whose patients include those with major medical illnesses and those requiring major surgical procedures. We are a full service medical center offering care in specialty areas of major cardiac procedures, open heart surgery, major orthopedic services, oncology, maternal-child care, dialysis, as well as general medicine and surgery.

The Medical Staff of Samuel Merritt Hospital conducts an extensive review of the case of each patient who expires in this facility, regarding medical management and overall care. The Quality Assurance Program assures that mortality review is an ongoing process at this hospital.

Samuel Merritt Hospital's specific mortality data reported by HCFA has been reviewed by the hospital administrators, Chief of the Medical Staff, Physician Chairmen of the Quality Assurance and Utilization Review Committees, Director of Quality Assurance and Director of Medical Records. Our overall percentage of deaths (10% - predicted range 8-15%), as well as those in each diagnostic category, are not only well within but are in fact closer to the lower end of each predicted national range. Considering the extreme illness of many of our patients, we feel that these statistics illustrate our commitment to clinical excellence. We are proud of the quality patient care delivered at Samuel Merritt Hospital.

Thank you again for the opportunity to present our response. We look forward to participating in future releases of patient care statistics.

Ronald Pavellas
Administrator

Kenneth Jensen, M.D.
Chief of Medical Staff

CD/nh

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human
Services
Washington, D.C. 20201

San Antonio Community Hospital

Dear Dr. Roper:

Thank you for the opportunity to respond to HCFA's scheduled December 1987 release of mortality information specific to San Antonio Community Hospital, Medicare provider #050099.

The data used by HCFA indicates that a total of 326 of 2,473 total Medicare patients admitted to San Antonio Community Hospital died within 30 days of admission. Of these, 256 died while still a patient of the hospital, while 70 died after discharge. Our own records indicate that 4,080 actual Medicare discharges occurred in 1986. Presumably the discrepancy reflects multiple admission of individual beneficiaries to San Antonio Community Hospital and other hospitals. All of the 256 in-hospital deaths have been verified by the Medical Record Department. It is impossible to verify whether the 70 post-hospitalization deaths reported actually occurred, as information concerning death after discharge is not included in the patient's medical record. However, our records indicate that all 70 of these patients were discharged alive from San Antonio Community Hospital.

At San Antonio Community Hospital, the major service departments (Surgery, Medicine, Family Practice, Pediatrics, Obstetrics and Gynecology, Psychiatry and the Emergency Room) continually perform mortality review. These departments will continue to review deaths that are included in your statistics and will be able to assist us in responding to requests for information that may occur.

We have also utilized our integrated Quality Assurance Program to have the Medical Staff and hospital personnel perform continuing review of the quality and appropriateness of care given at San Antonio Community Hospital. Generic screening criteria have been approved and are used by all of the major service departments of the Medical Staff in addition to all departments of the hospital. These screening criteria provide a systematic approach for the identification of areas of concern involving the care and

treatment patients receive while hospitalized at our facility. Any identified areas of concern, including mortality statistics, that appear higher than the state average, are investigated and the findings and recommendations reported to the Medical Staff, the Administration, and the Board of Trustees. Actions are taken when indicated. This comprehensive and ongoing system for monitoring patients care has been evaluated by several outside agencies during the last two (2) years, including the Joint Commission for Accreditation of Hospitals, and resulted in granting the highest level of accreditation.

Mortality review is only one of several important components of our quality control program. Our programs are designed to enhance patient safety, and reduce the probability of preventable adverse clinical outcomes. Quality of care is of the utmost concern to the governing boards, medical staff and management of San Antonio Community Hospital.

Again, thank you for the opportunity to present this response. If you or anyone receiving this material have additional questions, please do not hesitate to call me at (714) 985-2811, Extension 2111.

Sincerely,



George A. Kuykendall
Senior Vice President

GAK:cr

cc: Gilbert Turner, M.D., President, Medical Staff
A. Raymond Ellingson, M.D., Chairman, Utilization Review
John Thompson, Senior Vice President, Finance
Diane Kirk, R.N., Director, Quality Assurance
Elizabeth Guerra, Director, Medical Record

SAN BERNARDINO COUNTY MEDICAL CENTER

780 East Gilbert Street • San Bernardino, CA 92404 • (714) 383-3131



COUNTY OF SAN BERNARDINO

CHARLES R. JERVIS
Director, Medical Center
FRANCIS L. COMUNALE, M.D.
Medical Director

October 21, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
Post Office Box 26684
Baltimore, Maryland 21207

SUBJECT: 1986 MEDICARE MORTALITY STATISTICS - SBCMC PROVIDER NO. 050245

To whom it may concern:

The staff at the Medical Center has reviewed and analyzed the mortality statistics for the time frame of 1986. Further, as an ongoing process, our medical staff, through the appropriate quality review activities, reviews every case in which a patient expires. This review is not limited to Medicare recipients, but applies to all deaths occurring in the hospital.

Several items must be addressed and clarified in order to reach a true understanding of their significance as it applies to these statistics. The San Bernardino County Medical Center, as a County institution, serves a subset of the over 65 population which is not congruent with the over 65 population as a whole. This population is of a lower socio-economic status than the general population, is prone to have life styles which are not conducive to good health, and tends to use the hospital as its physician without having a long term relationship with the medical practitioner. This is reflective in the fact that 90% of these patients were admitted on an emergency or urgent basis and less than 10% of these cases were elective requiring pre-certification numbers.

Our overall mortality rate exceeded the range of predicted mortality rates of approximately 2%. However, in only one category, that of gastrointestinal catastrophies, did we exceed the range of predicated mortality rates. In this particular category, there were 14 cases with 7 deaths and the resultant 50% mortality rate exceeded the predicted mortality rate by 5%. Of interest in this category were the secondary diagnoses of the patients who did expire. These diagnoses were as follows:

Patient #1) Acute Chronic Ulcer Disease
Patient #2) Chronic Liver Failure with Massive Necrosis of the Liver
Patient #3) AIDS
Patient #4) Carcinoma of the Pancreas
Patient #5) Leukemia
Patient #6) Carcinoma of the Lung
Patient #7) Chronic Liver Failure

As can be seen by these secondary diagnoses, "death" would not be the unexpected outcome.

HEALTH CARE FINANCING ADMINISTRATION

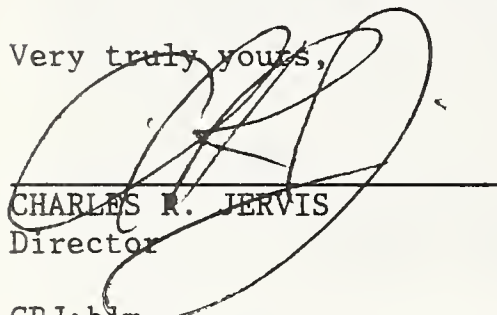
October 21, 1987

Page Two

In closing, the hospital wishes to call to your attention, the fact that the Medicare patients are a small proportion of our admissions. Indeed, only 562 cases were identified in this study. Because of the small number of cases, individual patient deaths can skew the results very quickly.

If you have any questions regarding this matter, please contact me at (714) 387-8188.

Very truly yours,



CHARLES R. JERVIS
Director

CRJ:blm



The
San Bernardino
Community Hospital

October 27, 1987

ROBERT S. LUND
Administrator and Chief Executive Officer

Re: Mortality Data

To Whom It May Concern:

The San Bernardino Community Hospital is a 322 bed acute care facility that provides services in the following areas that includes treatment for major medical and surgical illnesses, psychiatric, rehabilitation, maternity and newborn, chemical dependency for both adults and adolescents, and eating disorders.

The Medical Staff of The San Bernardino Community Hospital monitor every death in our facility on an on-going basis. We believe that our monitoring system provides us with a continuous feedback mechanism in an effort to continue to meet and exceed quality care standards.

The HCFA mortality data has been reviewed and the following summarizes our findings of the review:

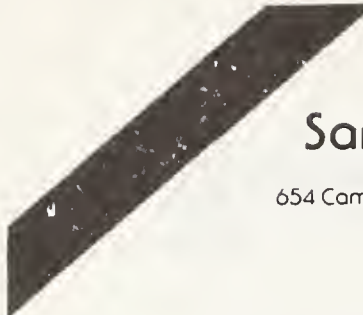
- 1) Of the seventeen diagnostic categories, two had no deaths.
- 2) All fell within the range of predicted mortality rates.
- 3) For severe acute heart disease, it should be noted that:
 - A. Average age was 75.
 - B. One-third of the patients experienced massive heart attacks and despite aggressive treatment, expired within hours after admission.
 - C. Majority of these patients were admitted with serious additional medical conditions.
 - D. All but three were admitted from the Emergency Room.

We thank you for the opportunity to present this response and to clarify the mortality data. The San Bernardino Community Hospital is committed to continue to provide excellent health care to our patients in the Inland Empire.

Sincerely,

Robert S. Lund

ROBERT S. LUND,
Administrator and C.E.O.



San Clemente Hospital

654 Camino de los Mares, San Clemente, CA 92672
(714) 496-1122

October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Md. 21207

Dear Dr. Roper:

Thank you for this opportunity to respond to HCFA's recent release of data on hospital mortality and average length of stay.

Since receiving the report in October, 1987, a number of people at San Clemente Hospital have had the opportunity to review the data:

- * Our Directors of Utilization Review and Medical records have validated that HCFA's data is accurate and a reflection of statistics at our facility.

- * Our Medical Staff and its Department representative have reviewed every death at San Clemente Hospital as well as those in the HCFA report.

- * Our Chief of Staff has reviewed and discussed the findings with the Department Chairpersons.

Based on this comprehensive review of HCFA's data and the specific medical records which it reflects, we think you and any member of the public who requests a copy of our statistical information will be interested in the following findings:

- * Reviewing the statistics it is apparent that San Clemente Hospital fell within the predicted ranges overall and in specific categories. Further analysis of data reveals 90% of all deaths were in high-risk category, 45% of deaths after discharge were sent to nursing homes, and 67% of deaths after discharge were in the high-risk category.

Based on our review of this and previous data, San Clemente Hospital continues to take the following steps:

- * We share significant findings with the entire Medical Staff so they will be able to respond to any questions their patients may ask.



* On an ongoing basis, our Medical Staff Tissue and Transfusion Committee reviews every death in our facility for appropriateness of care.

* The members of our Quality Assurance Programs place a continued emphasis on studies that will vigilantly monitor the care being provided to all patients at San Clemente Hospital.

Again, thank you for the opportunity to present this response. If you or anyone receiving this material have additional questions, please do not hesitate to call me at (714) 661-4402.

Sincerely,


Thomas W. McClintock
Administrator

San Clemente Hospital

654 Camina de los Mares, San Clemente, CA 92672
(714) 496-1122

October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Md. 21207

CONFIDENTIAL MEMO

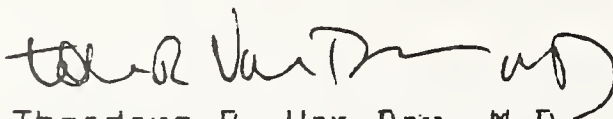
Dear Dr. Roper,

This confidential memo is sent in request to withhold the mortality data for San Clemente Hospital regarding the following ophthalmic review: In reviewing the data you will see that there was only one death and two cases. The Medical Staff and Administration of San Clemente Hospital believe that the release of the data could be a breach of confidentiality. This breach of confidentiality is due to the potential for discovery of the patients' and/or physicians' identity.

Thank you for honoring our previous proposal and for your consideration of this request.

Sincerely,


Thomas W. McClintock
Administrator


Theodore R. Van Dam, M.D.
Chief of Staff





Physicians & Surgeons Hospital

446 26th Street, San Diego, California 92102 (619) 234-4341

October 27, 1987

Health Care Financing Administration
Hospital Mortality Data
6300 Security Blvd.
The Meadows East Building, Room 2D2
Baltimore, MD 21207

Thank you for the opportunity to comment on the mortality data which has been compiled and will be released in the near future by California Medical Review Inc. Attached you will find the results of the research we conducted on our facility's data. Please include this information with any release of our Hospital's specific data.

Thank you for your cooperation in this matter.

Sincerely,

Dale Surowitz
Administrator

DS/sb
enc.

cc: Chief of Staff
QA/Medical Records Director
UR Director
QA Chairperson
Div. Sr. Vice President

CA 396

MEDICARE STATISTICS - SAN DIEGO PHYSICIANS & SURGEONS HOSPITAL - 1986

TOTAL MEDICARE PATIENTS DISCHARGED	745	(Includes Deaths)
TOTAL MEDICARE DEATHS IN FACILITY	67	

HCFA REPORTED DATA - 1986

1. HCFA Reported 58 Medicare Deaths within 30 days of admission to SDPS.
2. All of these deaths fell in the range of predicted mortality rates. (See attached report)

COMMENTS: - DATA VERIFICATION

1. Of the 58 deaths reported by HCFA we have verified that 47 occurred at SDPS.
2. Of the 11 deaths occurring outside our facility we have verified:
 - A. 1 death in SDPS Skilled Nursing Facility
 - B. 1 Patient readmitted to SDPS and expired 3 days later. (Not included in HCFA data.
 - C. 9 Patients expired elsewhere (unknown)
3. Of these 9 remaining patients:
 - 4 Discharged to home
 - 2 Convalescent Facility
 - 1 Intermediate Care Facility
 - 3 Another Acute Facility

Please see attached report for individual diagnosis and condition on discharge.

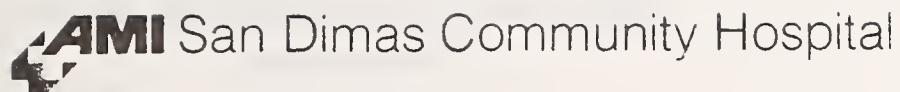
4. Of the 11 deaths outside our facility the following data was noted by HCFA:
 - A. 7 were classified as high risk
 - 1 Unknown
 - 3 Low Risk

After investigating the three (3) low risk cases, our data found that two (2) of these patients fell into a high risk category.

[REDACTED] classified as GI (Low Risk) Patient also was diagnosed with CA of the colon.

[REDACTED] classified as HL (Low Risk) also was diagnosed with CA of Lung.

5. All Medicare deaths are screened for quality of care and referred to the appropriate Medical Staff Committee if questionable.
6. Data substantiates that our facility's Medicare patients are not being prematurely discharged.



San Dimas Community Hospital

October 23, 1987

Provider # 050588

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Sirs:

Since receiving the mortality data for San Dimas Community Hospital for the year 1986, it has been carefully reviewed by hospital administration, Chief of our Medical Staff, Chairman of the Utilization Review Committee, UR/DRG Physician Advisors, Medical Records Director, and Director of Quality Assurance and Utilization Review. In all categories noted, the overall percentage of mortality is within the predicted range for our hospital.

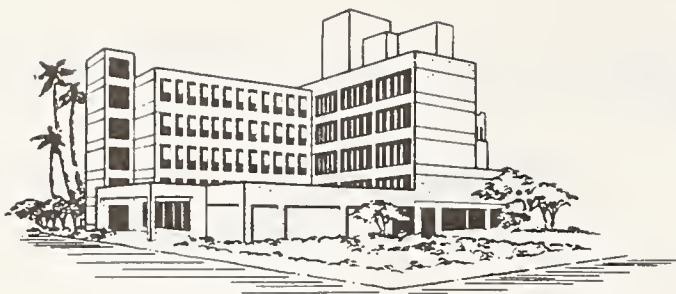
Mortality review is an on-going process of the Quality Assurance program, and monitoring of our health care delivery system is supported by peer review activities. We will continue to review all mortality cases for quality and appropriateness of care rendered. In reviewing the mortality data, it was noted that in the majority of cases, the sample size was too small to be of statistical significance. Although descriptor information about each beneficiary has been captured for a variety of patients, i.e., age, sex, admitting diagnosis, previous admissions, transfers, and the presence or absence of selected comorbidities, actual severity of illness and complications have not been measured in all cases.

San Dimas Community Hospital is a 99-bed acute care facility with more than 400 physicians, registered nurses, and other professional support staff. Eighty percent of the hospital physicians are Board Certified or Board Eligible. The Hospital recently received the maximum accreditation by the Joint Commission of Accreditation of Hospitals. Patients aged 65 or over of San Dimas Community Hospital have the benefit of post-hospital care from home health care and well-care from the recently opened Senior Health Center.

Sincerely,

A handwritten signature in cursive script that reads "Ruben A. Fernandez".

Ruben A. Fernandez
Chief Executive Officer



San Joaquin Community Hospital Corporation

2615 EYE STREET • P.O. BOX 2615 • BAKERSFIELD, CA 93303-2615
PHONE (805) 327-1711

October 27, 1987

William L. Roper, M.D.
HCFA
Health Standards Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper,

San Joaquin Community Hospital is a multi-specialty facility with emphasis in Cardiac and Cardiovascular services, Pulmonary Medicine and Oncology. The hospital has 181 beds with two high technology Intensive Care units staffed by the best Critical Care nurses available. The ICU's are considered the best in Kern County and receive critically ill patients from all outlying areas and also from other local hospitals when cardiac services are required.

San Joaquin Community Hospital is a leader in Health Education Programs for the general population in the Kern County area. Seminars on Weight Control, Cancer Prevention and Diabetes are offered throughout the year at a nominal fee. The Stop Smoking Plan, and Low Cholesterol Cooking classes are designed to promote public awareness of the individual's responsibility in caring for their health. The "Heartbeat" program offers every participant a medically supervised Coronary Risk Evaluation at a minimal cost. This program is provided weekly enabling many community members to participate.

The San Joaquin Hospital Mortality Statistical data reported for 1986 does not indicate a deviation from the predicted range. However, each case was reviewed and we appreciate the opportunity to present our findings. We feel we have a fine institution offering quality medical care and want to explain any variables that are not addressed in the comparative statistics. The diagnostic categories are listed and addressed individually.

CA Cancer

Total Cases 182

The predicted mortality range is 20 - 37%. The actual rate is 32% representing 58 cases.

It should be noted that:

Oncology represents a major service area.

A "No Code" status was requested by forty-seven (47) patients and/or their family members.

In addition to "No Code", three (3) families requested that chemotherapy be discontinued.

Eight (8) patients expired within the first twenty-four hours after admission.

Six (6) deaths occurred after the discharge date listed:

Two (2) patients discharged to Skilled Nursing Facilities.

One (1) family postponed all further treatment and took the patient home.

One (1) patient was readmitted to San Joaquin and expired in the hospital. The HCFA data does not reflect the second admission

Two (2) patients were discharged home and presumably expired of terminal cancer.

TR Severe Trauma

Total Cases 44

The predicted mortality range is 3 - 23%. The actual rate is 16% representing 7 cases.

It should be noted that:

A "No Code" status was requested by three (3) patients and/or their family members.

Three (3) deaths occurred after the discharge date listed:

One (1) patient was transferred to a Skilled Nursing Facility.

Two (2) patients were discharged home. The exact cause of death is unknown.

CE Cerebrovascular Accidents

Total Cases 182

The predicted mortality range is 18 - 39%. The actual rate is 35% representing 26 cases.

It should be noted that:

A "No Code" status was requested by twenty-three (23) patients and/or their family members.

One (1) case was coded incorrectly. The appropriate category was cancer.

Two (2) deaths occurred after the discharge dates listed:

Both patients were discharged and returned to the Emergency Room. The patients expired in the Emergency Room due to cardiopulmonary arrest.

GI Gastrointestinal Disease

Total Cases 210

The predicted mortality rate is 3 to 10%. The actual rate was 8% representing 18 cases.

It should be noted that:

A "No Code" status was requested by nine (9) patients and/or their family members.

Four (4) patients had serious cardiovascular comorbidities.

Three (3) deaths occurred after the discharge dates listed:

Two (2) patients were transferred to Skilled Nursing Facilities and expired. One of these patients had a "No Code" request.

One (1) patient was discharged home and expired three weeks later. The exact cause is unknown.

EY Opthalmoeogic Disease

Total Cases 50

The predicted mortality rate is 0 - 23%. The actual rate is 0%.

GC Gastrointestinal Catastrophies

Total Cases 28

The predicted mortality rate is 8 - 39%. The actual rate is 25% representing 7 cases.

It should be noted that:

A "No Code" status was requested by three (3) patients and/or their family members.

GU Urologic Disease Total Cases 61

The predicted mortality rate is 2 - 17%. The actual rate is 3% representing 2 cases.

It should be noted that:

One (1) case should have been coded with carcinoma as the principle.

A "No Code" status was requested by the two (2) patients and/or their family members.

One (1) patient had severe cardiac and respiratory co-morbidities.

One (1) death occurred after the discharge date listed:

One (1) patient was discharged to a Skilled Nursing Facility and expired with terminal cancer.

GY Gynecologic Disease Total Cases 30

The predicted mortality rate is 2 - 17%. The actual rate is 0%.

HL Low-Risk Heart Disease Total Cases 479

The predicted mortality rate is 3 - 7%. The actual rate is 4% representing 18 cases.

It should be noted that:

A "No Code" status was requested by eight (8) patients and/or their family members.

Four (4) deaths occurred after the discharge date listed:

Two (2) patients presented to the Emergency Room with cardiopulmonary arrest. Both had been recent inpatients.

One (1) patient was discharged to a Skilled Nursing Facility and presumably succumbed to one of nine cardiac co-morbidities.

One (1) patient was discharged home. The cause and place the patient expired is unknown.

HM Severe Chronic Heart Disease Total Cases 79

The predicted mortality range is 14 - 33%. The actual rate is 19% representing 17 cases.

It should be noted that:

A "No Code: status was requested by eleven (11) patients and/or their family members.

Two (2) deaths occurred after the discharge date listed:

One (1) patient was readmitted and expired in the hospital. The data records his death but not the second admission date.

One (1) patient discharged home and expired. The exact cause is unknown.

HS Severe Acute Heart Disease Total Cases 96

The predicted mortality range is 26 - 47%. The actual rate is 42% representing 39 cases.

It should be noted that:

Twenty-seven (27) cases were coded with the principle diagnosis of 410 Acute Myocardial Infarction.

San Joaquin was the only hospital in Kern County with a cardiac cath lab and cardiac surgery team.

Six (6) patients were transferred from various geographical areas requiring air transportation to San Joaquin. The unavoidable delay in services certainly increases the probability of mortality.

Four (4) patients expired within twenty-four (24) hours of admission.

Four (4) deaths occurred after the discharge date listed:

One (1) patient expired two days after transfer to Skilled Nursing Facility.

One (1) patient returned to the Emergency Room after discharge with a cardiopulmonary arrest and expired one day later.

One (1) patient was referred at discharge to another hospital in Los Angeles for electrophysiology testing. The patient expired eight days after discharge. The place and exact cause are unknown.

The disposition of the fourth patient was home. The cause of death is unknown.

ME Metabolic/Electrolyte Disturbances Total Cases 41

The predicted mortality range is 13 - 41%. The actual rate is 34% representing 14 cases.

It should be noted that:

A "No Code" status was requested by seven (7) patients and/or their family members.

Eight (8) deaths occurred after the discharge date listed:

One (1) patient refused SNF care and was discharged home.

Three (3) patients were transferred to Skilled Nursing Facilities. Two (2) of these patients had terminal cancer.

One (1) patient returned to San Joaquin Community Hospital one day after discharge and expired with a cardiac arrest. The place and cause of death for the remaining patients is unknown.

OP Orthopedic Disorders Total Cases 32

The predicted mortality range is 0 - 19%. The actual rate is 0%.

PN Pulmonary Disease Total Cases 160

The predicted mortality range is 15 - 30%. The actual rate is 27% representing 43 cases.

It should be noted that:

Seventeen (17) patients had serious cardiac co-morbidities.

A "No Code" status was requested by thirty-two (32) patients and/or their family members.

Seven (7) patients expired within twenty-four hours of admission.

Two cases should have coded with terminal cancer as the principle diagnosis.

Four (4) deaths occurred after the discharge date listed:

Three (3) patients expired in a Skilled Nursing Facility.

One (1) family requested to take patient home to die.

RN Renal Disease Total Cases 9

The predicted mortality range is 5 - 61%. The actual rate is 22% representing 2 cases.

It should be noted that:

One (1) patient was transferred in from a Skilled Nursing Facility and made a "No Code".

SE Sepsis Total Cases 16

The predicted mortality range is 13 - 58%. The actual rate is 31% representing 5 cases.

It should be noted that:

A "No Code" status was requested by four (4) patients and/or their family members.

One (1) death occurred after the discharge date listed:

One (1) patient was transferred to a Skilled Nursing Facility. The Patient had refused hemodialysis in spite of renal failure.

UN All other Conditions

The total number of cases is 22.

It should be noted that:

Two (2) cases appear coded incorrectly and should be in the category for carcinoma.

A "No Code" status was requested by ten (10) patients and/or their family members.

Six (6) patients had serious cardiovascular co-morbidities.

Three (3) patients expired within 24 hours of admission.

Six (6) deaths occurred after the discharge date listed:

One (1) patient was transferred to a Skilled Nursing Facility. The place and cause of the other Five (5) patients death was unable to be determined.

Respectfully submitted,

Kevin Fischer /s/

Kevin Fischer
Vice President, Finance



San Joaquin General Hospital / A Division of San Joaquin County Health Care Services

October 23, 1987

William L. Roper, M.D.
Administrator
Department of Health and Human Services
Health Care Financing Administration
2-D-2 Meadows East Building
6325 Security Boulevard
Baltimore, M.D. 21207

Dear Dr. Roper:

I have enclosed here San Joaquin General Hospital's response to the mortality information planned for release by HCFA in December.

Thank you for providing us with this opportunity to have comments included with the statistics for our hospital.

Sincerely,

Michael N. Smith, Director
Health Care Services

MNS:lvw

cc: William Brock, M.D.
Senior Surgical Consultant

enclosure

OCTOBER 1987

San Joaquin General Hospital's Response
Medicare Admissions and Mortality Information
Calendar Year 1986

Medicare admissions for calendar year 1986 are approximately 11% of all admissions, with an average age for this population of 67 years. However, at least 30% of this same patient group is 64 years or younger (many of them developmentally disabled). If this group is removed from statistical consideration, the average age of the Medicare group is 72 years. In addition, the average age among those Medicare patients who expire is 72 years (77 years if patients younger than 65 are removed from consideration).

Because of its special role as a public hospital, San Joaquin General receives a high proportion of patients who are characteristically more ill at time of admission than the overall patient population. Among the Medicare patients, more than 65% are admitted through the Emergency Room (86% of those who subsequently expire are emergency admissions). Factors which contribute to the severity of illness among some members of this patient group include low education and income levels, both of which tend to delay timely patient access to health care. Associated factors also include a high incidence of malnutrition, and a very direct correlation within this group between the severity of their illness and significant levels of tobacco and alcohol consumption.

Another significant aspect of this patient group is the comorbidity rate of 6 additional serious diagnoses which accompany the principal admitting diagnosis (an average of 7 among the group which expired). A number of these patients, because of their physical or mental condition, are considered problematic admissions for other area hospitals. Some of these include the homeless and those from such environments as Board and Care facilities and local hotels. Many of these patients lack familial support. All of these factors combine to present Medicare patients at San Joaquin General Hospital whose morbidity and mortality rates are significantly higher than the general patient population within the County.

These factors contribute to the length of stay and mortality rates within the Medicare population at San Joaquin General Hospital. Because of their condition at admission, they remain acutely ill for much of their stay. A small minority of these patients move from an acute level to either a Skilled or General Nursing level awaiting discharge (including placement in a nursing home or some other supervised environment). Length of stay thus tends to be prolonged, and the mortality rate is impacted by this seriously-ill patient population. About 30% of the Medicare patient expirations occur within 48 hours of admission. About one third of the deaths occur during the winter months of November, December, January, and February.

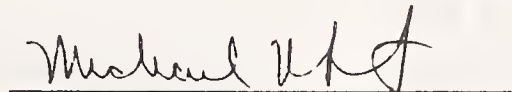
The 1986 mortality rates for Medicare patients at San Joaquin General Hospital all fall within the ranges predicted by HCFA, except for those with severe acute heart disease. The factors cited above in reference to patient characteristics are especially relevant to patients within this group and account for a slightly higher mortality rate.

Medical Review by

Submitted by

A handwritten signature in cursive script, appearing to read "William Brock", written over a horizontal line.

William Brock, M.D.
Senior Consultant

A handwritten signature in cursive script, appearing to read "Michael N. Smith", written over a horizontal line.

Michael N. Smith, Director
San Joaquin County Health
Care Services



SAN JOSE HOSPITAL

A Division of San Jose Health Center
675 East Santa Clara Street
San Jose, CA 95112
(408) 998-3212

October 23, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
PO Box 26686
Baltimore, Maryland 21207

SUBJECT: 1987 HCFA MORTALITY DATA RELEASE

The following constitutes our response to HCFA's 1987
Mortality Data release:

HCFA's 1987 mortality data were not adjusted
for acuity or severity of illness. These two
elements can make a significant difference in
individual facility's mortality rates. For this
reason, the relevance of the data must be questioned.

Sincerely,

Lorraine Grunewaldt-Fernandes /att

Lorraine Grunewaldt-Fernandes, RRA
Director of Medical Records/Utilization Review

cc: G. Lampros, M.D.
C. Leftwich, M.D.
J. Hanson, M.D.
D. Henderson, LVN
M. McDevitt, M.D.
C. Welter

An Affiliate Of

HEALTH
DIMENSIONS
INCORPORATED

THE GOOD SAMARITAN HOSPITAL
OF SANTA CLARA VALLEY
SAN JOSE HEALTH CENTER/
SAN JOSE HOSPITAL
WHEELER HOSPITAL
SOUTH VALLEY
HOSPITAL (1988)
HEALTH ADVANTAGE

CA 403



SAN PEDRO PENINSULA HOSPITAL

1300 West Seventh Street
San Pedro, California 90732
Telephone (213) 832-3311

October 27, 1987

William L. Roper, M.D.
Department of Health and Human Services
The Administrator
Washington, D.C. 20201

Re: MORTALITY INFORMATION -- MEDICARE PROVIDER NUMBER 050078

Dear Dr. Roper:

We appreciate the opportunity to respond to HCFA mortality information prior to it being made public.

Since receiving the report, we have reviewed the data. Our Manager of Medical Records has verified that with minor exceptions, the HCFA data is accurate.

For all cases overall, the actual mortality rate reported for San Pedro Peninsula Hospital fell within the predicted range. As a full service hospital, serving a high percentage of Medicare patients, we offer a wide range of services, including emergency care, intensive care and coronary care. In addition, we operate a subacute and extended care facility which serve primarily an elderly population. Also, our chronic dialysis unit and hospice program care for many seriously ill patients whose health has already been compromised by their conditions. These patients frequently have several comorbid or complicating conditions.

It is important to us to maintain high standards of quality and to do so we conduct extensive quality assessment which includes ongoing screening of all deaths and a thorough review of all deaths that do not meet screening criteria.

In the one category (sepsis) where the death rate exceeded the high point of the predicted range, our Director of Medical Quality reviewed every death. Through this review we have determined that the deaths fell within our expectations considering our patient population and the types of services we offer. We think the following factors give greater insight to our experience.

- o The HCFA data show that San Pedro Peninsula Hospital had a higher number of deaths in the diagnostic category of sepsis. This diagnosis applies to patients with infections of the blood.

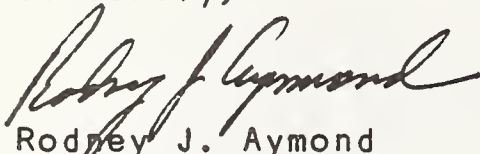
- o Of the deaths recorded in the sepsis category it was found that five of the ten reported deaths occurred within 24 hours of admission, an indication of the severity of illness.
- o SPPH serves a large Medicare population, accounting for 40 percent of our discharges. The average age of patients who died in the sepsis category was 73.6 years.

We are satisfied that when considered along with our special circumstances, the data accurately reflect our experience.

At San Pedro Peninsula Hospital mortality review is an ongoing process of the Quality Assurance program and medical staff involvement and peer review activities are an integral part of the monitoring of healthcare delivery at San Pedro Peninsula Hospital.

Again, thank you for the opportunity to present this response. If you or anyone receiving this material have additional questions, please contact me at (213) 514-5233.

Sincerely,



Rodney J. Aymond
President

RJA/ibi



October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
c/o The Health Standards Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Cottage Hospital Medicare Provider No. 050396

Dear Dr. Roper:

We appreciate the opportunity to respond to HCFA's release of Medicare mortality data scheduled for this December and respectfully request that the following information be attached to our report.

To the Santa Barbara community:

Cottage Hospital welcomes this move by HCFA to try and communicate appropriate and meaningful quality-of-care information to all users of hospital services. While HCFA itself admits that considerable refinements remain to be made in the methodology used to predict a hospital's expected mortality rate, we support this initial effort to promote consumer awareness, and look forward to continuing opportunities to discuss the quality of care and services at this hospital.

The importance of a strong quality assurance program has never been questioned at Cottage: The clinical departments of our medical staff review and monitor every death in our facility for appropriateness of care; ongoing analysis of patient care is the essential task of our quality assurance and utilization review programs; and the commitment of our board of directors is evident in the scrupulous attention to quality demanded by its subcommittee on quality care.

Any indication of potential problem leads to prompt and thorough investigation, and corrective action is taken swiftly to maintain the highest quality care levels. In other words,

William L. Roper, M.D.
October 23, 1984
Page 2

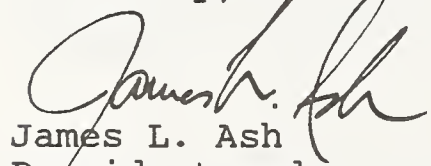
keeping a close watch on the degree and appropriateness of care at Cottage Hospital is something we have always done, and mortality review is an integral feature of our complete quality control program.

The mortality data reported here by HCFA have been carefully reviewed by our hospital administration, the president of our medical staff, the physician chairman of our utilization review committee, the director of our medical records and utilization review departments, and the staff of our quality assurance program. By analyzing a cross-section of these deaths reported by HCFA, we can validate that the data essentially are correct--with minor discrepancies in case numbers reported by HCFA. For example, in the Gastrointestinal Disease and the Severe Acute Heart Disease categories, our records indicate a higher number of 'Cases' which in turn decreases the 'Actual Mortality Rate' for these categories. We have been unable to resolve these discrepancies in the HCFA statistics.

Next year marks the centennial year of Cottage Hospital's founding. From a 25-bed facility serving a town of 5000, we have grown to become the largest and most sophisticated medical center and teaching hospital on the California coast between Los Angeles and the Bay Area. With 601 licensed beds and a medical staff of more than 500, we are fully accredited by the Joint Commission, having met its highest standards for hospital care.

The commitment made 100 years ago to provide health services to a growing community is no less strong as we enter our second century. We exist to serve the elderly and the newborn, the well-to-do and the homeless, continuing to stand as the major referral center for the critically ill of this county and beyond. Our patients are treated by some of this nation's most highly trained specialists, and cared for by nurses of compassion and skill. And this hospital continues to benefit from the generosity of a community who believes in its right to the very best in health care.

Sincerely,



James L. Ash
President and
Chief Executive Officer



William A. Davidson, M.D.
Director of Medical Affairs

Santa Clara Valley Medical Center

751 South Bascom Avenue
San Jose, California 95128
(408) 299-5100



Administration Office

751 South Bascom Avenue
San Jose, California 95128
(408) 299-6827

October 26, 1987

William L. Roper
Administrator
Health Care Financing Administration
P.O. Box 26684
Baltimore, Maryland 21207

Dear Mr. Roper:

Thank you for the opportunity to respond on behalf of Santa Clara Valley Medical Center to the upcoming release of Medicare Mortality Data from the Health Care Financing Administration. Hopefully, the public controversy created by the initial March 1986 HCFA release of unedited, raw data can be avoided and the public better served.

While I concur with your observation that data of this sort is limited in use and not a complete measure of the quality of care at an individual hospital, I am pleased that Santa Clara Valley Medical Center's overall Medicare mortality rate is within the HCFA predicted range. Although the statistical model used by HCFA for this data release appears to be more sophisticated than the first model, it nevertheless fails to consider a number of variables related to mortality rates. For example, variables such as the socio-economic status of the patient have been statistically correlated to the health status of the patient yet are not included in the type of analysis about to be published. Santa Clara Valley Medical Center is recognized by the Medicare program as a "disproportionate share" provider reflecting the composition of our patient population.

Mortality data of this sort also fails to recognize or acknowledge the unique position that Santa Clara Valley Medical Center maintains in this community. Santa Clara Valley Medical Center, as a teaching facility affiliated with Stanford University School of Medicine, routinely accepts not only the poorest patients, but also those with the most medically complex and difficult problems. Additionally, SCVMC provides a full spectrum of tertiary services including both trauma and burn centers.

The mortality data provided to us has been reviewed in detail by representatives of our Medical Staff, Nursing Staff, Medical Records Department, and Hospital Administration. The data accurately identifies those patients who expired at SCVMC. Each of the medical records for those patients in two categories where SCVMC exceeds the predictive range has been reviewed in detail (gastro-intestinal catastrophes and pulmonary disease). In no case was there any

SCVMC is an EEO/AA Employer

Created and owned by the

Santa Clara. Affiliated with Stanford University School of Medicine

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

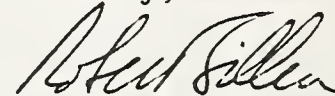
William L. Roper
October 26, 1987
Page 2

indication of anything but the highest level of medical care having been provided to the patient. I should also note that all deaths occurring at SCVMC are reviewed by standing committees of the Medical Staff as part of our ongoing Quality Assurance Program.

It should also be noted that given the small number of patients involved, a shift of one or two patients has a significant impact on the mortality rate. In fact, a shift of a total of only three patients would have placed both of the categories noted above into the so called "predicted range." Given the population of patients treated at SCVMC and the fact that your model does not address some very critical variables related to patient mortality, the data tends to confirm what we at SCVMC have known all along, Santa Clara Valley Medical Center provides an exemplary level of care to the most financially and/or medically needy sectors of our community.

In summary, while we continue to believe that mortality data of this sort is a meaningful first step in developing a base of information upon which sound public policy can be formulated, it is critical that the public understand the limitations of such data and that misguided inferences or comparisons not be made.

Sincerely,



Robert Sillen
Executive Director

RS:1jj

Santa Monica
Hospital
Medical Center

1225 Fifteenth Street
Santa Monica, CA 90404
(213) 319-4000

Leonard LaBella, Jr.

President and Executive Director

October 22, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Dear Dr. Roper:

This letter is in reference to your correspondence of September 21, 1987 regarding the mortality information for Medicare patients treated in Santa Monica Hospital during calendar year 1986. Our Medicare Provider Number is 05-0112.

Our response is as follows:

The provision of the highest possible quality of medical care has been and will remain the principal objective of Santa Monica Hospital. The fact that for the previous decade this hospital has received the maximum allowable accreditation by the Joint Commission on the Accreditation of Hospitals (JCAH) is public testimony that our commitment to quality care established by the Board of Trustees, Medical Staff and Administration has been realized.

Santa Monica Hospital recognizes and supports the efforts of public and private agencies and individuals to develop accurate measures of health care quality. To achieve that result, the measures must be both "valid" (i.e., they measure what they are designed to measure) and "reliable" (i.e., the measurement devices used yield the same result if the phenomenon being measured has not changed). Finally, we believe that whatever measures of quality that are developed are based upon data that includes a representative group of all patients and not just those 65 years or older.

Like many others in the health care community, Santa Monica Hospital has serious questions about the use of Medicare patient death (mortality) rates as "surrogates" for making inferences about the "quality" of hospital and physician care.

In the correspondence that accompanied the release of this data the Health Standards and Quality Bureau of the Health Care Financing Administration states: "we cannot and do not recommend the use of the information ... to make judgments about the quality of care in an individual hospital or to make comparisons between hospitals." We concur in this assessment. We trust that the public and the press will do likewise. It is our position that the publication of this data has the potential for generating more "heat" than "light" relative to public concern over issues of health care quality.

Many problems exist with regard to the use of mortality data as a "stand-in" for provider quality. Undoubtedly, the major problem with this data (a limitation recognized by the Health Standards and Quality Bureau in their accompanying letter) is the fact that the data on which these death rates are based does not take into account the severity of the illnesses experienced by the patient prior to his (or her) death.

Few would question that severity of illness does not effect the likelihood of a patient's chances of survival either while in the hospital or in the period immediately after being discharged.

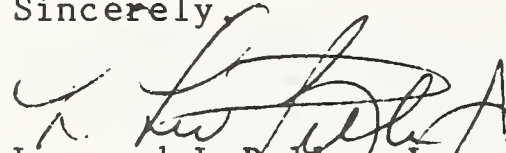
With all of the limitations and qualifications mentioned above, Santa Monica Hospital is pleased with our results. A review of our performance within the 16 diagnostic categories used to group the data provides additional evidence that we continue to provide quality medical care to the patients we serve. Santa Monica Hospital's actual mortality rates in all cases fall well within the predicted ranges on all 16 diagnostic categories. In no case does our position within a specific diagnostic range fall into the top quartile (e.g., one-fourth) of the range.

Overall, Santa Monica Hospital's actual performance, taking into account all diagnostic categories, lies near the bottom quartile of the predicted range of mortality.

To summarize, Santa Monica Hospital Medical Center cautions the public and press alike about the use and interpretation of this data relative to the assessment of health care quality. While pleased with our performance, we urge extreme caution in the interpretations based upon mortality data of this type.

Thank you for the opportunity to comment.

Sincerely,


Leonard LaBella, Jr.
President & Executive Director



Santa Rosa Memorial Hospital

A Sisters of St. Joseph of Orange Corporation

1165 Montgomery Drive, P.O. Box 522 Santa Rosa, California 95402 (707) 546-3210

October 23, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

To whom it may concern,

The mortality statistics for Medicare patients treated at Memorial have been reviewed by Memorial's Quality Assurance Committee, Utilization Review Committee, and Chief of the Medical Staff. The fact that data specific to Memorial falls within the ranges of predicted mortality rates given reflects the quality of care provided by Memorial.

Memorial maintains an ongoing mechanism for review of individual cases and their outcome through its Medical Staff committees and Quality Assurance Department, which identify any irregularities and take remedial action.

Memorial welcomes inquiries by the public and will address any concerns regarding the mortality data.

Sincerely,

George L. Heidkamp
President

Medicare provider number: 050174

Regional Medical Centers Administration
1924 Broadway
Oakland, California 94612
(415) 428-6242



October 26, 1987

William Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Re: Kaiser Foundation Hospital, Santa Teresa, California
Provider No. 05-0604

Dear Dr. Roper:

The Kaiser Permanente Medical Care Program has a long record of interest and involvement in the development and use of methods to adequately risk adjust outcomes of hospital care for patients with diverse risks at admission. This year's HCFA analysis has incorporated many improvements which we suggested in our published critique of the HCFA outliers data released last year. We will continue to cooperate with HCFA and other responsible agencies in efforts to further improve these methods to make the findings more useful.

Nationally, the 28 Kaiser Foundation Hospitals (KFH), located in four states, had 39 mortality rates which were below the tolerance ranges predicted by HCFA while only four rates were above these predicted ranges. HCFA reported up to 17 mortality rates for each hospital, and the range for each was intended to include 95% of all hospitals. Thus by chance alone, twelve of the KFH mortality rates would be expected to be higher than HCFA's predicted ranges, with another twelve lower than these ranges.

This favorable 39 to 4 ratio of mortality statistics for KFH hospitals needs little or no explanation. Nevertheless we are concerned by HCFA's use of risk models which cannot be critically evaluated at this time. Unaccountably, HCFA has not released sufficient data for an objective outside review of their method (e.g., no coefficients of variables in the models, no expected death rates). Despite this limitation, our preliminary review of the mortality risk adjustment models for 1986 Medicare discharges indicates serious problems which greatly reduce their value as useful measures of hospital care.

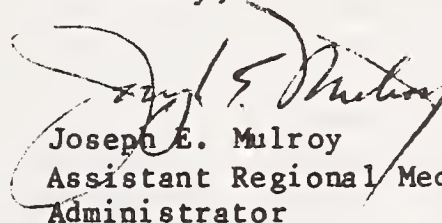
One of the most apparent problems is due to the fact that nearly all the 16 disease categories contain principal diagnoses which differ greatly in their mortality rates. The eight chronic comorbidities used as the key risk adjusters are not adequate to overcome these large differences. For this reason, hospitals can vary considerably in their risks, even after applying the models' adjustments.

Some illustrations of omitted risk factors follow:

- CA - Cancer care cannot be judged from a single hospital episode, particularly when there are no risk factors to measure either the extent of the disease or whether the case was admitted for scheduled surgery. Admission for terminal care is certainly a key risk factor for cancer deaths, and this in turn depends on the availability of alternate sources of such care, for example, hospice and home care programs. While admissions to HCFA-certified hospices were excluded from the 1986 discharge data, we believe that admissions to hospice units in short-term hospitals which had not sought HCFA approval were generally included, even when no charge for this care was made to HCFA. This would lead to inclusion of hospice cases at some hospitals and not at others.
- GI - Gastrointestinal disease includes the principal diagnosis of inguinal hernia (code 550). Most cases with this diagnosis are admitted for scheduled hernia repair surgery, which is very low in risk. However, some hernia cases are emergency admissions which are much higher in risk (e.g., strangulated hernias).
- HS - Severe acute heart disease is likely to be dominated by acute myocardial infarction, which is generally much lower in risk than other cases in this category (e.g., ruptured aortic aneurysm, cardiac arrest).
- TR - Severe trauma risk depends largely on the type, extent and combinations of injuries, none of which is distinguished by the risk model.

We are constantly seeking methods of improving patient care and welcome any assistance in developing better ways of monitoring our efforts.

Sincerely,



Joseph E. Mulroy
Assistant Regional Medical Centers
Administrator

We would like to coordinate further inquiries regarding this data through:

Daniel Danzig
Public Affairs
Kaiser Permanente Medical Care Program
1814 Franklin
Oakland, California 94612
(415) 428-6320

cc: J. Chappell



Richard M. Bracken
Executive Director

Direct Line: 619 457-8610

October 13, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
Post Office Box 26684
Baltimore, Maryland 21207

RE: Green Hospital of Scripps Clinic Medicare Provider #05-0424

Dear Sir/Madam:

The Green Hospital of Scripps Clinic would like to take this opportunity to comment on the release of the 1986 Medicare mortality information.

We believe that there are certain inherent limitations related to the data collection and reporting format that preclude definitive analyses. Primarily, the limitations of the data model are that it has not been validated and that the classification process uses limited patient characteristics. The model fails to consider a wide range of factors with significant effects on mortality including the patient's general health status or the stage of disease or disorder. Additionally, the limited number of patients (discharges) in many of the Diagnostic Categories result in small sample populations and potentially misleading averages. Finally, the inclusion of patient deaths within thirty days of discharge introduces conditions that may not be attributable to the care received during hospitalization.

We would hope that the recipients of this data recognize these types of limitations and use caution in their analyses and/or conclusions. Thank you for this opportunity to comment on the data release.

Sincerely,

Richard M. Bracken
Executive Director
GHSC Administration

RMB/mm

SCRIPPS MEMORIAL HOSPITAL -ENCINITAS
COMMENTS REGARDING HCFA'S RELEASE OF MORTALITY DATA

Medicare Provider Number: 050-503

Scripps Memorial Hospital-Encinitas is a 93-bed acute care community hospital serving the growing health care needs of San Diego's North County. Scripps Memorial Hospital-Encinitas offers a full range of services with the exception of obstetrics.

Review of the quality and appropriateness of patient care is an integral function at Scripps Memorial Hospital-Encinitas. Mortality is just one of many indicators that require immediate referral and review by the appropriate peer review committee. Nursing and ancillary departments are also responsible for monitoring the quality and appropriateness of patient care provided. If a patient care issue or trend is identified, appropriate action is taken by the peer review committee and follow-up is performed until the problem is resolved.

The HCFA mortality list for patients who expired at Scripps Memorial Hospital-Encinitas has been reviewed and several discrepancies were noted. Two patients who appeared on the HCFA list were discharged or transferred from our facility. Also, two of the discharge dates were incorrect. Attached is a corrected copy of our mortality data. Of course, we are unable to verify the deaths which occurred outside of our facility as this information is not included in the patient's medical record. Also, without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, we are unable to verify the accuracy of the diagnostic or other data used in HCFA's analysis.

Scripps Memorial Hospitals supports the principle of communicating appropriate and meaningful quality of care information to consumers. We welcome the opportunity to discuss our record of good care as substantiated by our comprehensive quality assurance activities.

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

SCRIPPS MEMORIAL HOSPITAL-LA JOLLA
COMMENTS REGARDING HCFA'S RELEASE OF MORTALITY DATA

Medicare Provider Number: 050-324

Scripps Memorial Hospital-La Jolla is a 452-bed acute care community hospital serving the health care needs of San Diego County. In addition to offering a full range of acute care services, we also provide regional and county-wide services such as our designation as a County Trauma Center and our status as a Regional Cancer Center. Scripps Memorial Hospital-La Jolla also provides specialized services such as open heart surgery, chemical dependency rehabilitation, and ophthalmic procedures. We are proud of our over 60-year contribution in providing quality health care.

Scripps Memorial Hospital-La Jolla has in place an extensive and comprehensive hospital-wide quality assurance program which assesses each episode of care against the highest possible standards of care. Each review is conducted during a patient's hospitalization in order to impact immediately the quality and appropriateness of health care decisions.

Mortality is just one of over 40 indicators that require immediate referral and review by an appropriate hospital and medical staff peer review committee. Nursing and the ancillary departments have developed ongoing quality assurance monitoring programs to ensure that the care provided is timely, accurate, appropriate, and meets Scripps Memorial's standards. If a patient care issue or trend is identified, appropriate action is taken by the peer review committee and follow-up is performed until the problem is resolved.

The HCFA mortality list for patients who expired at Scripps Memorial Hospital-La Jolla has been reviewed and appears to be accurate. Of course we are unable to verify deaths which occurred outside of our facility as this information is not included in the patient's medical record. Also, without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, we are unable to verify the accuracy of the diagnostic or other data used in HCFA's analysis.

Scripps Memorial Hospitals supports the principle of communicating appropriate and meaningful quality of care information to consumers. We welcome the opportunity to discuss our record of good care as substantiated by our comprehensive quality assurance activities.

Scripps Memorial Hospitals

9888 Genesee Avenue
Post Office Box 28
La Jolla, California 92038-0028

(619) 457-4123

SCRIPPS MEMORIAL HOSPITAL-CHULA VISTA
COMMENTS REGARDING HCFA'S RELEASE OF MORTALITY DATA

Medicare Provider Number: 050-270

Scripps Memorial Hospital-Chula Vista is a 159-bed acute care community hospital serving the health care needs for the South Bay population of San Diego County. SMH-Chula Vista offers a full complement of acute care services.

Review of the quality and appropriateness of patient care is an integral function of Scripps Memorial Hospital in Chula Vista. Since the hospital's inception in 1964, mortality cases, along with many other quality indicators, have been reviewed to assess the hospital's performance.

As part of the hospital's quality assurance program, each mortality is reviewed by the appropriate medical staff committee to ensure quality patient management and diagnosis. In addition, quality assurance review is performed by nursing and professional staff to assist in the identification of patient care issues which require action, follow-up, and problem resolution.

The HCFA mortality list for Scripps Memorial Hospital-Chula Vista has been reviewed and appears to be accurate. Of course we are unable to verify the deaths which occurred outside of our facility as this information is not included in the patient's medical record. Also, without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, we are unable to verify the accuracy of the diagnostic or other data used in HCFA's analysis.

Scripps Memorial Hospitals supports the principle of communicating appropriate and meaningful quality of care information to consumers. We welcome the opportunity to discuss our record of good care as substantiated by our comprehensive quality assurance activities.



SENECA DISTRICT HOSPITAL
P.O. Box 737
Chester, California 96020
(916) 258-2151

October 22, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Medicare Provider No. 050333

Gentlemen:

We are responding to your Health Care Financing Administration (HCFA) plan to publish selected mortality information on Medicare patients treated in 1986 within our hospital.

Seneca District Hospital is a 26-bed facility with 14 acute and 12 skilled nursing beds. We are located in Chester, California and serve the residents of Chester, Westwood and the Lake Almanor Basin. As a small rural hospital in the Sierra-Cascade mountains, we also serve a large population of seasonal summer residents and visitors who include fishermen, hunters, skiers and tourists. The nearest full service medical center is situated 70 miles West and healthcare to that area is accessible by transport via automobile, ambulance and helicopter. Our medical services include family practice, general surgery, internal medicine, obstetrics and orthopedics.

In 1986 we provided inpatient services for 476 patients and outpatient services for 3,838 patients. 2818 patients were treated in the emergency department and 66 babies were born at Seneca. Our case mix index was 1.07.

During 1986, seven (7) Medicare patients that were admitted to this hospital died within 30 days of admission. Three (3) elderly patient deaths exceeded the range of predicted mortality according to the HCFA statistical analysis. One of these patients who resided outside of this community was admitted to Seneca at the patient's request to maintain a level of comfort and care during the last days of the terminal illness. This patient was later transferred to a skilled nursing level of care prior to the patient's demise. This death was not a result of the health care given, but rather due to the terminal disease condition. Another patient was admitted for hospitalized care for a

A public entity providing health care services.

Health Care Financing Administration
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207
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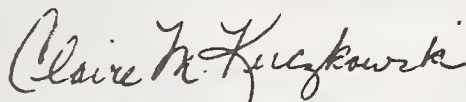
Medicare Provider No. 050333

terminal illness. The patient was later discharged home to supportive family and friends. Public assistance on a daily basis was provided by Hospice. Physician followup care allowed the patient to die within the home environment. The third patient was a 95 year old transferred from a convalescent hospital in another community and was admitted primarily for the treatment of a fractured femur (hip). This patient experienced multiple health problems and was admitted to the acute hospital for the prosthetic replacement of the fractured femur as a way to control the patient's severe pain. This patient was returned, in stable condition, to the skilled nursing facility of residence following the surgical recovery and later died, apparently from another illness.

The quality of care of all these patients was never compromised, but their diminished health was such, that a recovery was not possible. Our hospital, Medical Staff and personnel are committed to provide the best care possible in an effort to maintain quality care for all of our patients.

Sincerely,

SENECA DISTRICT HOSPITAL



Claire M. Kuczkowski
Administrator



Sequoia Hospital District

Whipple & Alameda
Redwood City, CA 94062
(415) 369-5811

September 30, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Mortality rates at Sequoia Hospital, as reported in the present data release, are for each diagnostic category either within or below the range of predicted mortality rates. Actual rates are slightly above the midpoint of the predicted ranges in only three of the seventeen categories; all of the others are at or below the midpoint, in some cases actually below the predicted minima.

From the standpoint of how well our actual rates compare with the predicted rates, our experience is one of low mortality.

As proof-positive of our quality standards of care, it is not possible to derive that much satisfaction from this comparison. The means of analysis employed is too single-dimensional an approach to a matter as complex as the quality of care.

Only eight co-morbidity factors are taken into consideration. Only five age brackets are employed. A good severity of illness measure is not incorporated into the regression formula. In short, there is no demonstration that a positive correlation exists between the data presented and quality of care standards at the hospital.

As far as it goes, the analysis indicates that outcomes of care at Sequoia Hospital are very fine. Our concern is that this means of analysis goes only skin-deep, that consumers and others will come to rely upon this kind of information to signify more than the data sustain, and that the public be misled (by this and future data releases) that the rates are an adequate and accurate measure of quality care.

Sincerely,

Richard R. Daniels
Administrator/CEO

RRD:ph



Serra Memorial
Hospital & Health Center

9449 San Fernando Road
Sun Valley, California 91352
(818) 767-3310

HOFA/EXEC.SEC.
OCT 28 PM 1:54

October 23, 1987

The Administrator
Department of Health & Human Services
Health Care Financing Administration
Washington, D.C. 20201

Dear Administrator:

This is in response to your recently released mortality information regarding Medicare patients treated in hospitals in 1986.

The Medical Executive Committee reviewed the thirteen cases listed in the category of acute heart disease and would like to make the following statement:

Out of the thirteen cases listed, four of the patients did not have any cardiac problems, and one patient had terminal cancer as well as a cardiac problem. The remaining patients all had chronic heart problems with poor cardiac status and died of cardiogenic shock. One patient also had chronic renal failure.

Serra Memorial Health Center has an excellent quality assurance program in place and all deaths are reviewed for appropriateness of care. In all cases listed under acute cardiac disease, all were found to have had appropriate care with all known measures of treatment given.

Sincerely,

Betty J. McCall
Chief Executive Officer

mmcW



Seton Medical Center

- 05-0289

Seton Health Services

1900 SULLIVAN AVENUE DAILY CITY CALIFORNIA 94015 (415) 992-4000

PART I

General Overview of Hospital and HCFA Data

The hospital is a 357 bed acute care hospital providing state of the art medical care. Because an unusually high percentage of patients are admitted for treatment of very serious conditions, the hospital must maintain a complex array of services. This complexity is measured by a formula called the Case Mix Index, which compares complexity and severity of illness at each hospital to a hypothetical standard community hospital. The Case Mix at this hospital is 1.5546, compared to the norm of 1.000, meaning that our patients are admitted with an acuity index 55% higher than the norm. Only 1% of the other hospitals participating in the Medicare program in the entire United States have a higher complexity index value per the Federal Register, June 3, 1986. The factors contributing to our high complexity are listed below:

Over thirty percent of the hospital's admissions are through the emergency room, indicating patients in a fragile, emergency condition. Approximately forty percent of our admissions are Medicare patients which means that we serve a large elderly population, at risk for many chronic illness and multiple health problems.

The hospital has an oncology program certified by the American College of Surgeons. Only one third of the acute care hospitals in the state offer certified cancer programs. We offer chemotherapy, radiation therapy, surgical services, an Oncology Care Nursing Unit and an outpatient Hospice Program for these patients, as well as care during the terminal phases of their illness.

The hospital is a major referral center for Cardiovascular Surgery Services. Nearly 700 open heart surgeries per year are performed here. We receive patients from other areas of the U.S. and other countries. Our high volume and referral status contribute to our complexity of services. The Heart Institute, located at the hospital, an educational and research institute that pioneers new procedures for the treatment of heart patients, has resulted in a hospital case load which includes over 1000 PTCA (Percutaneous Transluminal Coronary Angioplasty) procedures per year, and is doing basic research on other non surgical treatment modalities for maintaining the patency of coronary vessels.

This hospital was within the predicted death percentage range in all diagnostic categories reported in the 1986 Medicare Morbidity Data release. Two categories, Cerebrovascular Accidents and Severe Acute Heart Disease, were impacted by the particularly complex and acutely ill patients sent to this hospital (as measured in the past by the cases mix index). The reputation of the cardiovascular program has resulted in the more complex heart patients being referred to this hospital, therefore the HS "Severe Acute Heart Disease" mortality rate is at the top of the predicted range, however, not exceeding the predictable rates. The CE "Cerebrovascular Accidents," or strokes are likewise effected. The thirty-seven patients who died had an average age of 80. In addition to the significance of this average age, it should be noted that over 25%

St. Catherine Hospital - On Half Moon Bay - San Francisco Heart Institute - Seton Associates - Seton Medical Office Centers
Seton Health Services Foundation - Seton Institute for International Development - Western Hansen's Disease Institute

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The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

died within a day of admission indicating the severity of their Cerebrovascular Accident, with another approximately 20% dying within the first three days. All totalled, 75% died within the first week. All cases were reviewed by the Medical Staff for the appropriateness of their care.

PART II

Hospital Quality Review Activities

Hospitals are required by their licensure organizations, the Joint Commission on Accreditation of Healthcare Organizations, the Health Care Financing Administration (HCFA), the State Medical Association and the state licensing agency, to assure quality of care. This is accomplished by a structure of various hospital and Medical Staff Committees whose responsibility is to develop methods of evaluating the delivery of medical services. A number of Committees have been established by the hospital to ensure that this evaluation is accomplished including Quality Assurance, Utilization Review, Tissue Committee for surgical case review and blood usage analysis, Pharmacy and Therapeutics Committee and Infection Control. These required activities have evolved over the years as a self check and monitoring system to ensure that the hospital and Medical Staff members have a method for identification and resolution of problems. Additionally each month the members of each department review and evaluate the cases of patients who have had complications or die. The results of the review are reported to the Medical Staff Executive Committee and members of the Board of Directors. This mechanism is used to ensure that the medical staff and hospital monitor all health care delivery parameters to assure the best possible health care. Therefore, all the deaths reported in the HCFA release of 1986 deaths have already undergone Medical Staff monitoring and evaluation.

PART III

Health Care Financing Administration (HCFA) 1986 Medicare Patient Mortality Report

The data contained in the reports released by HCFA are for Medicare patients only, a population generally over the age of 65. Contained in this age group are many frail elderly with chronic conditions requiring hospitalization and treatment. The data lacks a severity of illness adjustment, thus mortality rates cannot be used to judge the quality of care. It is helpful to know something about the case mix index value of a hospital when evaluating mortality statistics. HCFA publishes a case mix index value for each participating provider in the Federal Register on a regular basis. Generalization of this data into the whole population, or ascribing the same treatment characteristics and mortality rates to another patient population would be inaccurate as the characteristics of other patient age groups are not the same.

The mechanism used in the Health Care Financing Administration (HCFA) data, numerical ICD-9 code assigned as the Principal Diagnosis or reason for admission to the hospital is a major change from the DRG grouping mechanism promoted by the Medicare Program at this time. This limits the available comparison data and the hospitals ability to validate the data attributed to it by HCFA as the method for analysis cannot be reproduced precisely. Inclusion of deaths occurring after a patient is discharged does not allow for validation of the reason for death. It is possible that a patient in this age category could die from a totally unrelated episode.

PART IV SUMMARY

It is important to keep in mind several factors related to the death rates prepared by the Health Care Financing Administration:

- o Death statistics would be more meaningful if adjusted for the patients severity of illness.
- o The diagnostic category for admission is not necessarily the cause of death.
- o Complications and other conditions which arise during a hospitalization are not apparent in the summaries presented.
- o The number of cases in a group highly influence the death rate percentage.
- o Comparisons using this information create many problems because of the differences in hospital services available, the kind of patients treated, and the hospital type, ie. urban, rural, university, teaching, etc.
- o Persons using this data to make generalizations about the quality of health care attributed to a specific hospital or geographic area are well advised to acquire additional information.

October 1975

St. Vincent's Hospital, On-Har Moon Bay, San Francisco Heart Institute, Seton Associates, Seton Medical Office Centers,
Seton Health Services Foundation, Seton Institute for International Development, Western Hansen Disease Institute

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SHARP

MEMORIAL HOSPITAL

CHARLES S. KOCH
Senior Vice President and Administrator

October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
6325 Security Blvd.
Baltimore, MD 21207

Dear Doctor Roper:

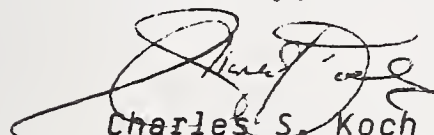
Thank you for the opportunity to review our 1986 hospital mortality data prior to public disclosure. We would like to request the following information be included with Sharp Memorial's data:

The Medical Staff at Sharp Memorial conducts an intensive review of every mortality at our facility regarding medical management. Mortality review is an ongoing process of the hospital-wide quality assurance program.

The hospital specific mortality data reported by HCFA has been carefully reviewed. Our actual mortality rate for all the diagnostic categories was within the range of predicted mortality rates.

Thank you for the opportunity to present this response.

Sincerely,



Charles S. Koch
Senior Vice President
and Administrator

CSK/cj



Community Hospitals of Central California

Fresno & "R" Streets, Fresno, CA 93721 / P.O. Box 1232, Fresno, CA 93715, (209) 442-3996
James D. Helzer - President and Chief Executive Officer

October 23, 1987

William L. Roper, M.D.
Department of Health & Human Services
Health Care Financing Administration
The Administrator
Washington, D.C. 20201

Dear Dr. Roper:

This letter is in response to your Administration's planned release of mortality data on the three acute hospitals which make up the Community Hospitals of Central California. Our three acute hospitals, Clovis Community Hospital, Sierra Community Hospital, and Fresno Community Hospital and Medical Center have reviewed this data and your analysis regarding the specific mortality data on Medicare patients who were treated between January and December, 1986.

In response to the data presented about our three hospitals, we would like to make the following general comments about your analysis.

1. All of our facilities indicate normal ranges of mortality rates in the vast majority of the diagnostic categories compared to other hospitals in the nation. We are proud of our overall status in relationship to all causes of death among our Medicare patients during the 1986 calendar year.
2. We have reviewed each of the documents for our facilities in detail and have found small inaccuracies which deal with some of the diagnostic listings and also the period of time in which it was administered. In the case of Sierra Community Hospital, only 10 months during the 12 month period were actually recorded in the data reported in your findings. Indications also show that at Sierra Community Hospital several of the cases are of individuals who are on the average 80 years of age with a variety of secondary diagnoses such as diabetes, chronic pulmonary disease, emphysema, and renal failure; these are contributing factors to the mortality statistics indicated in your records.



BOARD OF DIRECTORS: Bud Richter, Chairman / Ken O'Brien, M.D., Vice Chairman / Lou Herwaldt, Vice Chairman / John Stoughton, Secretary / Elmer Nilmeier, Treasurer / Clifford Davis / Donald Fine / Gene Ford / Richard Ford / Reid Gromis / Ben Gutierrez / Joseph Levy / Kendall Manock / James Mayer / Wanda Rogers / Yoshito Takahashi / Edwin Wiens, M.D. / Joseph Woo, Jr., M.D.

Facilities: Clovis Community Hospital / Fresno Community Hospital & Medical Center / Sierra Community Hospital / Fresno Convalescent Hospital / Sierra Meadows Medical Service / Sierra View Convalescent Hospital



William L. Roper, M.D.

Page Two

October 23, 1987

3. Fresno Community Hospital and Medical Center, which is a major tertiary care center for the Central San Joaquin Valley, sees a high number of elderly and acutely ill patients. This results in our statistical mortality being higher in certain categories because outlying facilities transfer acutely ill patients to us because of our complete range of health care services.

It should also be mentioned that all of our hospitals continue to operate Quality Assurance Programs that monitor all patient data in all areas of medical and surgical specialties. Our three individual medical staffs have reviewed for appropriateness all of the cases outlined in your data and we will continue to strive for the highest possible quality of care available in the area.

In closing, we would hope that in the future releases of this data you would provide us with the individual hospital identification numbers, length of stay for each patient, the average age by diagnosis category and if this data could also be reported in alphabetical order by discharge date. This information would make it easier for our staffs to analyze the data and review its accuracy.

Thank you for your attention to our comments and if any additional information can be provided by our organization, please do not hesitate to contact me at your convenience.

Sincerely,

Melvin J. Wexler, Vice President
Marketing Strategy

MJW:jl

SIERRA VIEW LOCAL HOSPITAL DISTRICT

465 WEST PUTNAM AVENUE -- TELEPHONE 784-1110

PORTERVILLE, CALIFORNIA 93257

Public Entity

September 25, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, MD 21207

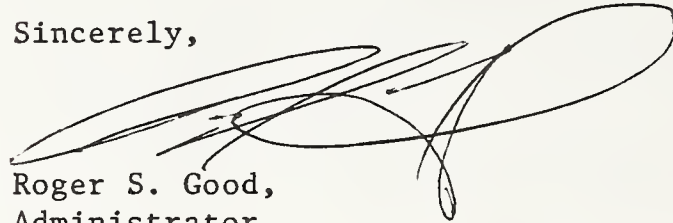
Re: Mortality Reporting
Provider 050161

Gentlemen:

From the information accompanying the individual hospital statistics on mortality reporting it is unclear why a death occurring within 30 days of admission that did not occur in the hospital would be attributed to that hospital and that disease entity.

It is also unspecified whether a death occurring within 30 days of admission to one hospital but occurring in another hospital would be identified with one or both of those hospitals.

Sincerely,



Roger S. Good,
Administrator

RSG:mrp



Sonora Community Hospital

One South Forest Road • Sonora, California 95370 • (209) 532-3161

Office Of
The President

October 15, 1987

William L. Roper, M.D.
Administrator
Department of Health & Human Services
Health Care Financing Administration
Washington, D.C. 20201

**Re: 1987 HCFA Mortality Rate Report for Sonora Community Hospital
(Medicare Provider Number 05-0335)**

Dear Mr. Roper:

We, at Sonora Community Hospital, appreciate the opportunity to provide this written response in advance of the publication of the Mortality Rate Report by the Health Care Financing Administration.

While we believe that there may be some difficulties inherent in using mortality rates as a measure of quality in healthcare, we do agree that the effort to provide the American public with reliable information on this important industry should not be discouraged. As an active participant in the provision of acute and long term care in a rural setting, we welcome this effort to improve American healthcare.

In reviewing the statistical information provided in this report, we are pleased to note that our facility appears to be within an acceptable range of the statistical thresholds represented. This data is based on an average patient census representing 53.22% of which are participants in the Medicare Program. We feel these statistics are a positive reflection on our contribution to the care provided to our local patient population.

Again, we applaud HCFA's effort to provide evidence of quality in healthcare to the consumers. We trust the publication of the information contained in this report will serve to further this effort. We feel this data can be utilized to further educate our consumers, as well as defining the contributions made by Sonora Community Hospital to the local community.

Any questions about our section of the HCFA report or any information provided in this response may be directed to me.

Sincerely,

Stan B. Berry
President

CA 440

SBB:sn

October 26, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

To Whom It May Concern:

In reference to HCFA's publication of the 1986 mortality data, South Bay Hospital would like to call your attention to its internal review of the data. In only one of sixteen areas did our statistics fall outside the predicted adjusted range. We have taken a close look at this area and our medical committees have scrutinized the 23 cases in the deviating category. Our actual rate is only 3% outside the predicted range and we feel that there is a pattern of utilization which skews the sample.

Due to the fact that the hospital does not have an Open Heart Unit and a Cardiac Catheterization Lab, patients in this community who are expected to need and benefit from these interventions are routed to two other local hospitals who do have these services. Additionally, many of those who do arrive in the facility and are candidates for these procedures are transferred after stabilization in the E.R. Therefore, those who are not candidates for angioplasty or cardiac angiography, often because they have pre-existing chronic diseases, remain here and show up in the diagnostic category. These same patients presenting with acute cardiac disease, complicated by chronic pre-existing disease, have, naturally, a higher mortality rate than the population at large.

In the future, should the hospital develop a cardiac catheterization program, the sample deviation should correct itself. In fact, the cardiologists treating these patients practice in all three local hospitals utilizing the same high personal standards of treatment and practice.

South Coast
Medical Center

October 26, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Sirs,

Thank you for the opportunity to provide input on the mortality statistics for the calendar year 1986.

We request that the following information be deleted as the facility's patient mortality in these diagnosis categories is so limited that releasing the information would breach confidentiality by implicitly or explicitly identifying the specific patients or physicians:

Diagnostic Category	Cases	Actual Mortality Rate	Range of Predicted Mortality Rates
SE Sepsis	4	25%	7 to 82%
ME Metabolic/Electrolytes Disturbance	23	9%	7 to 42%

This request is based on 476.101, a. and b. of the Federal Register Vol 50 No 74 Wednesday, April 17, 1985.

The following information for South Coast Medical Center is to be attached to the Hospital Specific Report for public disclosure.

South Coast Medical Center is a 268-bed, not-for-profit, general acute care hospital providing patient services ranging from critical care, out patient surgery, maternity services and a 24-hour emergency room to a chemical dependency unit and extensive rehabilitative services. Other services include an eating disorders program, pain management center, physician referral service and a mental health unit.

31872 Coast Highway
South Laguna, California 92677
714-499-1311

Health Care Financing Administration
Page 2
October 26, 1987

We have requested that Diagnostic Categories SE Sepsis and ME Metabolic/Electrolytes Disturbance be deleted from our report. Our actual mortality rates for both categories are very low. However, the request for deletion is based on the fact that the mortality in these categories is so limited that releasing the information would breach confidentiality by implicitly or explicitly identifying the patient.

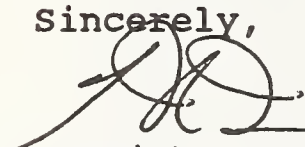
The Medical Staff at South Coast Medical Center conducts an intensive review of the medical record of every patient who expires at this facility regarding medical management and overall care. Mortality review is an on-going process of the Quality Assurance program and peer review activities are an integral part of the monitoring of the healthcare delivery system at this hospital.

The hospital specific mortality data reported by HCFA has been carefully reviewed by: the hospital administrators, President of the Medical Staff, Physician Chairmen of the Utilization Review and Quality Patient Care Committees, and the Director of Quality Review.

We are pleased that in all categories South Coast Medical Center is within, and on the lower end of, the range of predicted Mortality Rates for our hospital. This data indicates our continued commitment to providing quality care for our patients and the community we serve.

Thank you for the opportunity to present this response.

Sincerely,



T. Michael Murray, President
South Coast Medical Center



Paul Prewitt, M.D., Chief of Staff
South Coast Medical Center

VAD:lkv

xc

Sister Mary Columba Drive
Red Bluff, California 96080



ST. ELIZABETH COMMUNITY HOSPITAL

Phone (916) 527-2112

October 22, 1987

Dear Health Care Consumer:

Re: Mortality Statistics - HCFA Mortality Data Release
December 1985 - January 1987

Thank you for the opportunity to provide input on the mortality statistics for the period stated above. The data has been reviewed and found to be accurate with minor exceptions. We are pleased that the actual mortality rates are within the range of predicted mortality rate in all categories.

A total of 802 Medicare patients received medical care during the reporting time. Of these cases, 94 were deaths which occurred within thirty days of the last admission to the hospital. Twenty-four of these deaths occurred after discharge from St. Elizabeth Community Hospital.

The twenty-four deaths which occurred after discharge from the hospital have additional factors to be considered:

- "No Code" per patient and family request.
- Transferred to another acute facility for specialist care.
- Admitted after discharge from another acute facility.
- Patient discharged to home per patient/family insistence.
- Patient discharged to a Skilled Nursing Facility.

It should be noted that the only hospital admissions which are counted in this period are the ones closest to the date of death. One patient could have several admissions during this period, but for purposes of this study the other admissions are not counted. The death rate does not always indicate the cause of death. If a patient is admitted for a condition and also has a terminal condition the case would be included under the reason admitted and not necessarily the cause of death.

Mortality review is only one aspect of an ongoing process of the hospital-wide quality assurance program and peer review activities are an integral part of the monitoring of the health-care delivery system at this hospital.

Cases in which quality of care are an issue are further reviewed by the Quality Assurance Committee and reported to our Board of Directors.

SISTERS OF MERCY SERVING OUR AREA SINCE 1881

Re: Mortality Statistics - HCFA Mortality Data Release
December 1985 - January 1987

Page 2.
October 22, 1987

Although our mortality rates are within the predicted range, we will use analysis of this data as an educational tool in our endeavor to provide the highest quality of care to our patients at St. Elizabeth Community Hospital.

Sincerely,

A handwritten signature in cursive script, appearing to read "R. Michael Barry".

R. Michael Barry
President/CEO

RMB/chw

ST. FRANCIS HOSPITAL

601 East Micheltorena Street • Santa Barbara, California 93103 -1289 • Ph. (805) 962-7661
of Santa Barbara

October 19, 1987

Department of Health & Human Services
Health Care Financing Administration
Washington, D.C. 20201

Dear Sir:

We have reviewed the mortality data intended for release in December, 1987, and submit the following comments for collation with this data:

1. St. Francis Hospital of Santa Barbara has had a system of mortality/morbidity review in place for many years as part of our hospital-wide quality assurance program. All of the patient deaths reported by HCFA had already been reviewed by the appropriate departments of the Medical Staff.
2. St. Francis Hospital performed an in-depth analysis of our hospital-specific data in diagnostic category HS-Severe Acute Heart Disease, and found:
 - a. The total number of cases reported by HCFA was incorrect; the actual number of Medicare cases in this category was 48, not 40. These included the following cases:

[REDACTED]

- - b. The number of Medicare deaths reported by HCFA was incorrect; the actual number of Medicare deaths in this category was 20, not 21.
 - c. The actual mortality rate for Medicare patients in this category is 42%, not 53%.

Department of Health & Human Services
October 19, 1987
Page 2

- d. If all patients in this category are calculated into the mortality rate, it decreases to 32%.
- e. Of the 20 Medicare patient deaths in this category, 19 had chronic underlying ailments as listed by HCFA.
- f. Of the 20 patients who died, all but one received the major portion of their treatment in the CCU.
- g. The 20 patients who died had 17 different admitting physicians, and 17 different consultants involved in their care.
- h. Category HS is listed by HCFA as the highest risk diagnostic category.

Sincerely,



Louis J. Carlentine
President/C.E.O.

LJC/cal



Saint Francis Memorial Hospital

Post Office Box 7726 San Francisco, California 94120 (415) 775-4321

050152

Dear Health Care Consumer:

Saint Francis Memorial Hospital, an acute, non-profit community hospital, located near downtown San Francisco, is pleased to comment on the HCFA's mortality statistics.

Approximately 40% of our admissions are Medicare patients. In addition to a wide range of medical and surgical services, we offer the following specialized services: a sophisticated oncology (cancer) unit, a psychiatric service which includes both "locked" and "unlocked" areas, a burn center and a general intensive care unit as well as a coronary care unit.

The Medical Staff at Saint Francis Memorial Hospital conducts an intensive review of the medical record of every patient who expires at this facility with regard to medical management and overall care. Mortality review is an on-going process of the Quality Assurance program and peer review activities are an integral part of the monitoring of the healthcare delivery system at this hospital. The Joint Commission on Accreditation of Hospitals recently bestowed on this facility its highest commendations for the hospital Quality Assurance program and the excellent peer review process that is performed.

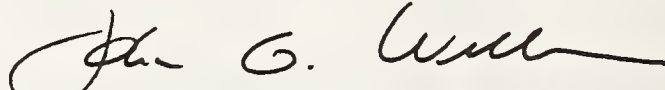
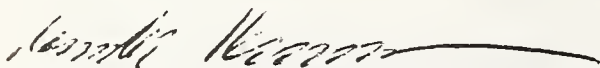
The hospital specific mortality data reported by HCFA has been carefully reviewed by: the hospital administrators, President of the Medical Staff, Physician Chairmen of the Utilization Review and Quality Assurance Committees and the Director of Medical Records. Our overall percentage of deaths is at the low end of the predicted range, and in no area did we exceed the predicted range. In fact, in 13 of the 16 specific diagnosis categories, the data shows we are below the midpoint of the range.

In the three diagnosis categories where we exceeded the mid-point of the range, a 100% case review was conducted. These cases included strokes, ruptured abdominal aneurysms, severe heart disease (heart attacks), and long-term kidney failure. In every case death was due to an acute, catastrophic episode that precipitated the admission and in many cases the patient suffered a recurrent event after the admission. In the few cases where the patient died after discharge, the discharge plan was evaluated and all were found to be appropriate.

Saint Francis Memorial Hospital is proud of its long history of delivering excellent service to the community and feels that these statistics will assist us in focusing our efforts for further improving the care delivered to our patients. We support all responsible efforts designed to assist healthcare consumers in making informed choices. If you have a question, please call:

Dick Slottow, Administration
(415) 775-4321 ext. 3210

Sincerely,



Kenneth J. Hammerman, MD; Chief of the Medical Staff
John G. Williams; President and CEO



October 21 1987

William L Roper, MD
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
PO Box 26684
Baltimore MD 21207

Dear Dr. Roper:

St. Helena Hospital & Health Center is a 165 bed acute care facility. We are a full service medical center offering care in specialty areas of open-heart surgery, vascular surgery and pulmonary rehabilitation, as well as general medicine and surgery.

Thank you for this opportunity to respond to the release of data on hospital mortality rates among Medicare patients for the calendar year 1986. Since receiving the report dated September 24 1986 St. Helena Hospital & Health Center has had an opportunity to review the data. The Director of Medical Records has validated that, with minor exceptions, the data is accurate.

The hospital specific mortality data reported by HCFA has been carefully reviewed by: the hospital administrators, President of the Medical Staff, Physician Chairman of the Patient Care Committee and Director of Medical Records.

We would like to comment that our overall percentage of death in each diagnostic category is within the range of predicted mortality rates. Anything within the range meets the expectation of the Medicare population.

Fourteen of the sixteen diagnostic categories are in the lower portion of the expected range.

Two categories are in the upper range, though still well within the HCFA expected range.

- Severe Chronic Heart Disease

Our Medicare patients who fell in this category are patients who have had long standing severe heart problems. These statistics represent 14 cases. Our hospital does in excess of 300 open-heart surgery cases per year.

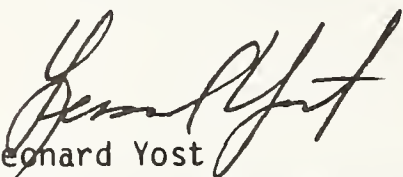
- Metabolic/Electrolyte Disturbance

All our patients who fell into this category were terminal patients transferred to our hospital from skilled nursing facilities. The average age was 80 and most had not been eating or drinking and needed intravenous fluid therapy.

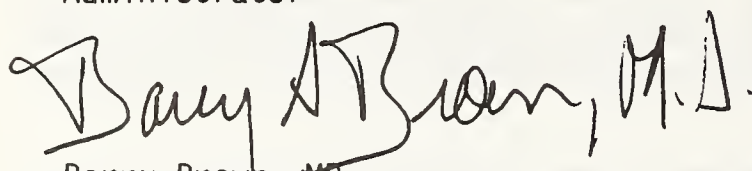
The Medical Staff of St. Helena Hospital & Health Center conducts as an integral part of health care monitoring an intensive review of the medical record of every patient who expires at this facility regarding medical management and overall care. The Joint Commission on Accreditation of Hospitals bestowed on this facility its highest commendations at their 1986 on-site review. We feel that our mortality data substantiates the excellent medical care delivered at St. Helena Hospital & Health Center.

Thank you for the opportunity to present this response.

Sincerely,



Leonard Yost
Administrator



Barry Brown, MD
Chief of Staff



St. John's Regional Medical Center

Division of Mercy Health System



October 26, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

To whom it may concern:

Enclosed is information for St. John's Regional Medical Center to be attached to the Hospital Specific Report for the period October 1, 1984 through September 10, 1986, prior to public disclosure.

Sincerely,

NORMA FORBES
Director of Planning



St. John's Regional Medical Center

Division of Mercy Health System



October 26, 1987

Dear Citizens:

St. John's Regional Medical Center is a 282-bed acute care facility providing a wide range of services including oncology, complete cardiovascular services, physical and rehabilitative medicine, dialysis and mobile lithotripsy. The hospital's case mix includes many patients with major medical and surgical illnesses.

The Medical Staff at St. John's Regional Medical Center conducts an intensive review of the medical record with regard to the medical management and overall care of every patient who expires at this facility. Mortality review is an on-going process of the Quality Assurance program, and peer review activities are an integral part of the monitoring of the healthcare delivery system at this hospital.

The hospital specific mortality data reported by HCFA has been reviewed, and St. John's is well within the predicted ranges of deaths among its Medicare population in each diagnostic category.

It is imperative that any reviewer acknowledge the limitations of this summary data by diagnostic category which does not reflect differences in diagnoses, procedures, severity of illness, case mix, age, complications and reason for death. This sort of statistical analysis can do no more than identify potential areas for further evaluation. Differences in data between hospitals should not be interpreted as a difference in quality of care.

However, St. John's supports the principle of communicating appropriate and meaningful quality of care information to consumers, and we welcome this opportunity to discuss the quality of care and services we provide.

Thank you for the opportunity to present this response.

Sincerely,

DAN HERLINGER
President

EDWARD GIBSON, M.D.
Immediate Past President
Medical Staff

333 North F Street • Oxnard, CA 93030 • (805) 988-2500

Sponsored by the Sisters of Mercy and caring for Ventura County since 1912

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Saint John's Hospital and Health Center

OFFICE OF THE PRESIDENT

October 23, 1987

William Roper, M.D.
Health Care Financing Administration
Health Standards Bureau
Hospital Mortality Information
P.O. 26684
Baltimore, MD 21207

Dear Dr. Roper:

Thank you for the opportunity to respond to the planned release of hospital mortality data by the Health Care Financing Administration in December, 1987. We wish to make the following comments available to any interested individuals reviewing the data specific to Saint John's Hospital and Health Center.

Saint John's mortality data task force thoroughly evaluated the data. Included on the task force are the Senior Vice President of Medical Affairs, the President of the Medical Staff, the Director of Utilization Management and the Director of Medical Records. The review process involved a comparison of HCFA's data with statistics generated by Saint John's for the same period. The group has validated that, with minor exceptions, the data is accurate.

The hospital-specific data includes 1986 statistics on the number of Medicare patients admitted under each of 17 diagnostic categories, the actual percent of those patients who died within 30 days of their last admission of 1986, and a predicted range or proportion of patients who would be expected to die based on the probability of death for patients of similar age, sex and condition.

For every diagnostic category reported, Saint John's mortality rate was within the predicted mortality range for that category. In fact, in all categories Saint John's actual rate was below the midpoint of the range.

This acknowledgment of the high standards of medical care practiced throughout our facilities is readily attributable to our medical staff, our excellent nursing staff and all of the other members of the medical teams who deliver on a daily basis the

(More)

CA 452

best that Saint John's has to offer. This holds true in Saint John's Heart Institute, Saint John's Cancer Center, and for the full range of our other specialty areas, as well as for general medicine and surgery.

It is also important to point out that mortality review is not a new procedure at Saint John's. The circumstances surrounding every death in our hospital are diligently reviewed by appropriate medical staff committees as an integral part of our quality assurance program and peer review activities.

We welcome the opportunity to discuss our commitment to the delivery of quality care and services. We do, however, urge the following note of caution: it is imperative that any reviewer keep in mind the limitations of this kind of data for Medicare discharges. Summary data such as this does not reflect the totality of circumstances surrounding treatment for a given patient. How ill was the patient at the time of admission? Was he/she transferred from a nursing home? Was the patient receiving treatment at home prior to admission? What was the patient's psychological state or general health status? These and a variety of other social and environmental factors can influence the outcome of treatment. Therefore, differences in mortality rates alone should not be used to judge the quality of care in a hospital or between hospitals. The data can serve as a useful starting point for further evaluation.

Thank you again for the opportunity to present this response to accompany the December release of HCFA's mortality data.

Sincerely,


Sister Marie Madeleine Shonka
President,
Saint John's Hospital and Health Center



1100 WEST STEWART DRIVE, ORANGE, CALIFORNIA 92668 (714) 633-9111

COMMENTS ON THE HCFA MORTALITY DATA

Data Verification

The data used by HCFA as to number of cases and mortality does not significantly differ from the Saint Joseph Hospital data, with the exception being that we lack specific data relative to deaths reported to have occurred after patient left the hospital.

Interpretative Remarks

In HM (Severe Chronic Heart Disease), Saint Joseph Hospital is shown to have a 29% mortality rate within a 15-30% predicted mortality range. Analysis of the 37 cases in which death occurred shows a total of 30 patients died in the hospital. Ages ranged from 62-99 with an average and median age of 77 years. Approximately 30% of the deaths of patients in this category represented readmissions for an agonal downhill course with an expected poor outcome (death), though their lives were prolonged and made more comfortable through the readmissions for supportive care. An additional 12% of these cases were transfers of patients from nursing homes who were admitted in an acute state.

Within this HM diagnostic category, we identified a total of 9 coding errors which would have resulted in the patients being assigned to another diagnostic category. This would have resulted in a death rate of 20%, well within the lower half of the predicted mortality range of 15-30%. Coding errors are reflected as follows:

- 2 cases originally coded as congestive heart failure turned out to be pneumonia and revised attestations were submitted, but are not reflected in HCFA data
- 2 cases admitted with acute renal failure were coded incorrectly as congestive heart failure (resulting in lower reimbursement to hospital)
- 3 cases in this category were actually acute myocardial infarctions and should have been coded into category HS
- 1 case represented a ventricular tachycardia arrhythmia, which also would have been correctly coded in the HS category
- 1 case represented a complete heart block, and should have been correctly coded in the HL category

Adjustments to the other actual mortality rates of diagnostic categories effected by the above coding errors would be as follows:

- HL - deaths increased by 1 case, mortality rate remains at 5% within a predicted mortality range of 3-8%
- HS - deaths increased by 4 cases, mortality range adjusted to 35% within a predicted mortality range of 28-52%
- PN - deaths increased by 2 cases, mortality range becomes 22% from a predicted mortality range of 13-27%
- RN - deaths increased by 2 cases, mortality range becomes 18% from a predicted range of 4-39%

Summary Comment

Saint Joseph Hospital believes these data from the HCFA files, demonstrating mortality rates for our hospital well within the predicted range of mortality rates in every category, affirms the excellence of our medical and nursing staffs and the quality of services being given to the Medicare patient population of our area.



St. Joseph's
Medical Center
of Stockton

Lawrence A. Philipp
Chief Operating Officer

October 27, 1987

William L. Roper, M.D.
Administrator
Department of Health & Human Services
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

I am in receipt of the selected mortality information for our hospital that HCFA will be releasing in December of 1987. The following is our response and clarification of the information submitted to us in your letter dated September 21, 1987.

The data used by HCFA indicated a total of 530 Medicare patients admitted to our medical center died here or elsewhere within 30 days of admission. Your report indicated that 426 died while still patients of our hospital, while 104 died after discharge. Our records state that of the 530 Medicare patients reported by HCFA, 439 actually died while patients of our hospital, while 91 died after discharge. The actual readmission to our hospital when the death occurred was not indicated on the HCFA print-out. Presumably, the discrepancy reflects multiple admissions of individual beneficiaries in different hospitals. These discrepancies have been highlighted in yellow on the attached sheets. It is also impossible to determine the percentage of the 91 patients dying after discharge who are in fact alive, as information concerning death after discharge is not included in the patient's medical record.

Although the use of a 30 day post-admission mortality rate will reduce apparent variations in mortality, due to differences in length of stay, it will also result in the attribution to our hospital of deaths that are unrelated to the condition of the patient that was under treatment at the time of discharge or that resulted from the management of the patient at home or in a post-acute care facility.

In summary, the final purpose of our commenting on the HCFA data is to emphasize the data in and of themselves should not be used as measures of hospital performance. At best they can be used to better focus quality assurance activities. Under no circumstances should they be used as the basis for judging the quality of care provided by our or other hospitals.

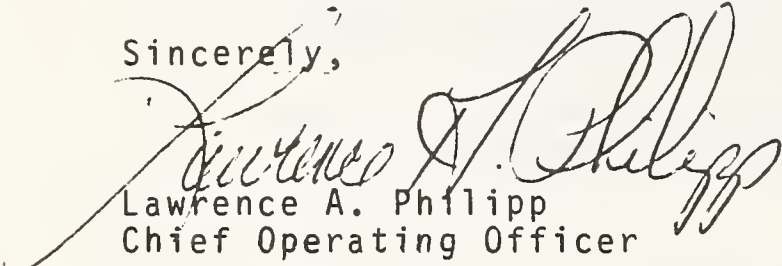
1800 North California Street, Stockton, California 95204 (209) 467-6313

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

William L. Roper, M.D.
October 27, 1987
Page 2

If you have any questions or comments regarding the above, I would be happy to discuss them with you.

Sincerely,



Lawrence A. Philipp
Chief Operating Officer

LAP:kr



October 22, 1987

Hosp # 050201

To Whom It May Concern:

In analyzing the data on mortality information I have noted an error. The principal diagnosis of 4140 was given for patient [REDACTED]. I have checked the medical record to verify this and found the code was resequenced.

The principal code should have been 4280 (congestive heart failure). Apparently the record was billed in error and we did receive a DRG change notice from the California Medical Review organization.

The change is a significant one because it takes the patient from a low risk heart disease category into a high risk group.

Enclosed are copies of pertinent supportive data. Thank you for your consideration.

Respectfully yours,

A handwritten signature in cursive script that reads "Toni Underwood".

Toni Underwood, ART
Medical Records Manager

2510 NORTH CALIFORNIA STREET • STOCKTON, CALIFORNIA 95204 • (209) 948-2100

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.



ST. LUKE MEDICAL CENTER

2632 East Washington Blvd., Box 7021, Pasadena, California 91109-7021 • (818) 797-1141

Medicare Provider #050029

October 23, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Dear Community:

The hospital mortality data for Medicare patients reported by HCFA has been carefully reviewed at St. Luke Medical Center by the hospital Administrators, the President of the Medical Staff, the Physician Chairman of the Utilization Review Committee, and the Director of Quality Assurance.

The Medical Staff of St. Luke Medical Center conducts an intensive review of the medical record of every patient who expires at this hospital regarding medical management and overall care. This mortality review is an on-going process of the Quality Assurance Program and peer review.

The actual mortality rate reported from all causes at St. Luke falls within the predicted range. We did, however, exceed the range for the diagnosis of Cancer. In the time period reported, 42% of our patients with an admitting diagnosis of Cancer succumbed to their disease. Many of these patients were admitted for treatment of complications due to their Cancer. Also, 83% of these patients had Cancer which had spread to other vital organs. In 87% of these cases, the staff of St. Luke Medical Center complied with the wishes of the patient and family not to resuscitate or use other means to prolong the life of the patient.

The Medical Staff of St. Luke Medical Center, as has been their practice, will continue to review all mortality cases for both quality and appropriateness of care to the individual. We feel that our monitoring system provides us with all the information needed to continue to meet and exceed the high quality standards set by the Administration and Medical Staff of St. Luke Medical Center.

Sincerely,

Harry F. Adams,
Executive Director

HFA:lw



October 25, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Hospital Mortality Information
6325 Security Blvd.
Meadows East Bldg., Room 2D2
Baltimore, MD 21207

Dear Dr. Roper:

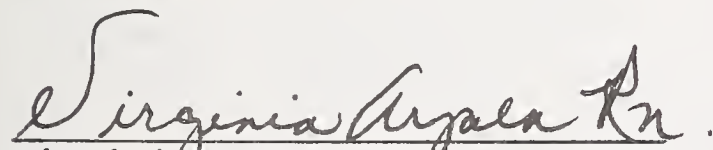
Thank you for the opportunity to comment on our mortality statistics for 1986.

St. Luke's Hospital intends to provide the community with quality medical care and welcomes every opportunity to reevaluate its services. Although we have an on-going, intensive review procedure where both physician department chiefs and hospital administrators carefully examine patient care, we once again analyzed our patient charts to see if we had further opportunities to meet the highest standards possible.

We are satisfied that appropriate and compassionate care was given in every instance, and our statistics for each diagnostic category fall well within your standards for California hospitals.

We commend your efforts to provide the community with information about health care.

Sincerely,


Virginia Ayala, R.N.
Chief Operating Officer

Sincerely,


Norman Miller, M.D.
Chief of Medical Staff

KR/l dm



St. Mary Medical Center

1050 Linden Avenue, Post Office Box 887, Long Beach, CA 90801, (213) 491-9000

October 21, 1987

William Roper, M.D.
Administrator
Health Care Financing Administration
6325 Security Boulevard
Baltimore, MD 21207

Dear Dr. Roper:

Thank you for the opportunity to respond to the Medicare mortality statistics for calendar year 1986. We have reviewed the data and find that it is generally accurate. St. Mary Medical Center is a 540 bed non-profit acute care facility that is part of the Sisters of Charity of the Incarnate Word Health Care System. We are also associated with the UCLA School of Medicine.

While we applaud the increased sophistication of the HCFA data analysis, there are still hospital and patient specific factors which may not be considered in your statistics:

1. As a teaching hospital associated with UCLA, St. Mary's provides care to patients who are more ill on admission and who have more complex medical problems.
2. As a level I trauma center, our emergency department received those patients who have suffered the most extreme and life threatening emergencies.
3. Because of our large, busy emergency department (the only paramedic base station in Long Beach), a high fraction of our admissions are admitted with urgent and emergent problems. These patients are generally sicker and have more advanced disease than the average.
4. St. Mary Medical Center has one of the largest hospice programs in Southern California. Although the program is designed to allow patients to die in the nurturing environment of a home, many terminally ill patients are admitted. Their mortality is a reflection of the breadth and quality of services offered at St. Mary Medical Center.

William Roper, M.D.

October 21, 1987

Page 2

Although your analysis attempts to account for some of the variables associated with these hospital characteristics, it does not address them all. As you can tell from my comments, St. Mary Medical Center is a complex, sophisticated institution which provides care to many types of patients. I hope that this information can be helpful to those who interpret the mortality data.

Sincerely,

A handwritten signature in cursive script that reads "David B. Tillman, M.D.".

David B. Tillman, M.D.
Associate Administrator

DBT:kjs



ST. MARY'S

HOSPITAL AND
MEDICAL CENTER

October 22, 1987

William L. Roper, M.D.
Administrator
Department of Health and Human Services
Health Care Financing Administration
Washington, DC 20201

Dear Dr. Roper,

We appreciate having the opportunity to comment on the hospital-specific mortality information for Medicare patients treated at our hospital in 1986. We believe however that this type of statistical data is not a complete measure of, nor does it correlate well with, a hospital's quality of care. The HCFA data reporting system lacks a reasonable and valid severity of illness measure, and is subject to significant misinterpretation by the public. At best, such data can do no more than identify potential areas for further study and evaluation, done most appropriately within the scope of a hospital's quality assurance program.

The reporting of predicted mortality rates and ranges is certainly not an exact science. As you know there are countless "gray areas" of uncertainty when one tries to take a selected amount of descriptive patient information and extrapolate to a reasonable probability that an individual patient with "similar" characteristics will die. To further cloud the issue with the publication of a range of percentages seems unfair to health care providers. Additionally, the inclusion of all deaths occurring within 30 days of admission, regardless of whether the date of death is post-discharge from the acute hospital, introduces the possibility of a patient's death being unrelated to the admitting diagnosis or the condition upon discharge, and occurring away from the acute facility.

Inconsistency in Medicare data reporting is a disservice to health care consumers. In California, recent data releases by the PRO, California Medical Review, Inc., categorized mortality data by DRG, and compared hospital averages to statewide averages. The proposed HCFA data uses eight diagnostic categories which are based on selected ICD-9-CM codes. These categories use "editorial" terms, such as gastrointestinal catastrophies, and low-risk heart disease. Comparisons are made only against an ill-defined standard. How can a member of the consuming public be expected to compare such data? Analysis is difficult even for health care professionals. We would encourage HCFA to validate its methodology of gathering and reporting Medicare mortality statistics, and to maintain that methodology in a consistent fashion, for the benefit of all involved.

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Page 2

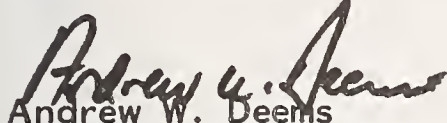
William L. Roper, M.D.

Department of Health and Human Services

October 22, 1987

We continue to share the desire to safeguard the quality of healthcare provided to the American public. Through our internal quality assurance program, we monitor and evaluate all of our clinical services and make ongoing efforts to educate our consumers as to appropriate utilization of these services.

Yours sincerely,

A handwritten signature in dark ink, appearing to read "Andrew W. Deems". The signature is fluid and cursive, with a large initial "A".

Andrew W. Deems
Acting President/CEO

AWD/vlm

ST. ROSE HOSPITAL FIRST IN FAMILY CARE

27200 CALAROGA AVENUE • HAYWARD, CALIFORNIA 94545 • 415 751-0200

October 22, 1987

Harvey Brook, Director
Office of Field Operations
784 East High Rise Building
6325 Security Boulevard
Baltimore, Maryland 21207

Dear Mr. Brook:

Thank you for the opportunity to respond to the release of data on Medicare hospital mortality rates for calendar year 1986. Since receiving the report, St. Rose Hospital staff has had an opportunity to review the data.

The Medical Records Manager has validated that, with minor exceptions, the data is accurate. The Quality Assurance Committee of the hospital Medical Staff has reviewed the cases reflected in this report.

The following information for St. Rose Hospital should be attached to the Hospital Specific Report for the 1986 period prior to public disclosure:

St. Rose Hospital is a 175-bed facility providing 129 beds of acute and 46 beds of skilled nursing care. Our case mix includes many patients with major medical and surgical illnesses. We are a full service hospital caring for a disproportionately poor and aged population.

The Medical Staff at St. Rose Hospital conducts an intensive review of the medical record of every patient who expires at this facility regarding medical management and overall care. Mortality review is an ongoing process of the Quality Assurance program and peer review activities are an integral part of the monitoring of the care provided at this hospital. The Joint Commission on Accreditation of Healthcare Organizations bestowed on St. Rose its highest commendations for the hospital Quality Assurance program and the excellent peer review process that is performed.

We were pleased to note the hospital specific mortality data reported by HCFA indicates St. Rose, in total, is within the range of predicted mortality for the population of patients we treat. Of the (16) diagnostic categories reviewed, St. Rose was below predicted mortality in (1), within range in (13), and over the range in only (2).

As previously stated, review by this facility is always by individual case regarding quality of care and is conducted in an ongoing fashion, not just when statistics such as the mortality data are released.

Thank you for the opportunity to present this response.

Sincerely,



DEAN VAN METRE,
President & Chief Executive Officer



MARION KRAMER, M.D.,
Medical Staff President

ST. VINCENT
MEDICAL CENTER

2131 West Third Street
PO Box 57920
Los Angeles, California 90057-0992



October 16, 1987

William L. Roper, MD
Administrator
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Care Financing Administration
Washington, DC 20201

Dear Dr. Roper:

Thank you for the opportunity to respond to HCFA's recent release of data on hospital mortality rates.

Some additional pertinent details regarding the nature and character of St. Vincent Medical Center are essential for any interpretation of this data.

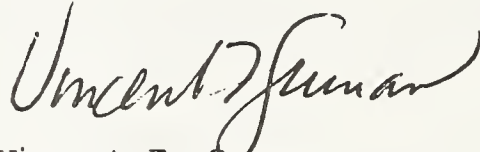
- o St. Vincent Medical Center has an active cancer program which is supported in part by the National Cancer Institute. Cancer patients at this institution have access to research protocols sponsored by national cancer treatment groups, and can receive therapies available at only 50 hospitals nationwide. The Los Angeles Oncologic Institute at St. Vincent was recently selected as the only hospital in Southern California to receive a Community Clinical Oncology Program grant to provide state-of-the-art cancer treatment. Many cancer patients seen at St. Vincent have advanced disease, as reflected in a mortality rate one percent beyond the expected range.
- o St. Vincent Medical Center is a regional referral center for the diagnosis and treatment of heart disease, and performs more open heart surgery than any other California hospital. Our statistics reflect our favorable experience with complicated heart surgeries and higher risk patients, and the large number of complex cases transferred to our facility from community hospitals.

William L. Roper, MD
October 16, 1987
Page Two

- o Because of the tertiary care focus of St. Vincent Medical Center, our case mix index is very high. This index reflects the severity of the illnesses treated at this medical center, by calculating the resources used in treating our patients. In all but one category, our mortality rate is within the expected range, reflecting effective care.

If you have further questions or comments, please call the Marketing Communications Department, (213) 484-5591.

Sincerely,

A handwritten signature in cursive script, reading "Vincent F. Guinan".

Vincent F. Guinan
President

VFG:11



STANFORD UNIVERSITY HOSPITAL

STANFORD UNIVERSITY MEDICAL CENTER

STANFORD, CALIFORNIA 94305 • (415) 723-5222

Sheldon S. King

President

Stanford University Hospital

October 29, 1987

William E. Roper, M.D.

Administrator

Health Care Financing Administration

Department of Health and Human Services

Washington, DC 20201

Dear Dr. Roper:

We are pleased to offer Stanford University Hospital's official response to the release of HCFA data on hospital mortality rates for October 1, 1984 through September 30, 1986.

We have analyzed the data carefully to help us in preparing the response. We find no notable inaccuracies in the published information. We are gratified to note that the hospital's mortality rates in all categories were within the range of predicted mortality rates.

Those relatively low mortality rates are particularly significant when the patient mix is considered. Stanford University Hospital is a tertiary care facility providing health care facilities to a patient population based primarily in San Mateo and Santa Clara Counties. It is also a major academic and research center with specialized services that attract patients with complex, life-threatening diseases who are generally at greater risk for increased morbidity and mortality than most hospital patients.

That greater risk is documented in several ways. One is the fact that according to the rating system for Medicare DRGs provided by HCFA, Stanford's severity of patient illness ranks among the highest in the nation. In addition, our patient acuity level ranks higher than other hospitals in the Santa Clara Conference when complexity is measured by the number of secondary diagnoses and the number of additional procedures per patient. Finally, a Severity of Illness Indexing research project conducted by Johns Hopkins University, and using a different set of measures, also shows Stanford's overall patient acuity to be among the highest of those hospitals rated nationwide.

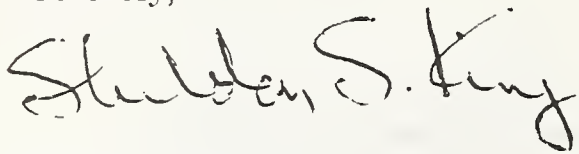
We consider the relatively low mortality rates at Stanford to be a reflection of the superlative medical staff, nursing team and other ancillary staff. The quality assurance process is another key factor. Stanford has a Care Review Program for monitoring patients that has been recognized nationally as a prototype for integrated review. Registered nurses track all Medicare patients throughout their hospitalization to make sure they receive appropriate services and to watch for the development of complications, particularly those that are life-threatening. Data collected through the review process are analyzed by a Medical Staff Committee responsible for the quality of care. This committee ensures that corrective measures are instituted if they are needed.

In addition, there are other medical staff committees that review specific aspects of patient care, such as infection control, surgical procedures and intensive care unit programs. Each medical service also conducts its own examination of hospital deaths and complications with the specific goal of improving medical treatment for future patients.

Patient deaths also are reviewed through a variety of ongoing mechanisms and we intend to use the HCFA data to intensify those reviews.

As a teaching hospital, we are constantly studying new and improved ways of treatment and of preventing avoidable complications. The HCFA mortality data should help us in achieving those goals.

Sincerely,

A handwritten signature in cursive script that reads "Sheldon S. King".

Sheldon S. King
President

A handwritten signature in cursive script that reads "John Wilson".

John Wilson, M.D.
Acting Chief of Staff

SSK:db

Sutter Solano Medical Center

October 23, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

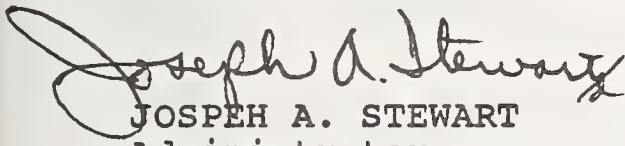
Gentlemen:

Attached are the comments from Sutter Solano Medical Center, Vallejo, California, Hospital 050101, to the mortality data to be included with any public release of this data.

Thank you for this opportunity to respond.

Sincerely,

SUTTER SOLANO MEDICAL CENTER



JOSPEH A. STEWART
Administrator

JAS/DKB/pf

Attachment

300 Hospital Drive • Vallejo, California 94589-2594
(707) 554-4444

COMMENTS ON THE HCFA MORTALITY DATA
SUTTER SOLANO MEDICAL CENTER, VALLEJO, CALIFORNIA

Sutter Solano Medical Center appreciates and welcomes the opportunity to present additional information about the HCFA mortality data. The hospital and medical staff are proud of their care and the Quality Assurance Program that monitors it. Last Fall our program was recognized as one of the most innovative and successful programs in the State of California.

The Data is Incomplete

The first issue to address is the incomplete manner in which the federal government collected the numbers. For example, the method used by the Health Care Financing Administration (HCFA) in determining mortality rates include counting a patient whose death occurred after his or her discharge from the hospital. Also, for those patients hospitalized several times during 1986, HCFA counts only one: the last visit! If we counted all the Medicare patients we treated last year, our mortality data would be as follows:

	# Medicare Patients <u>Treated</u>	# Deaths in <u>Hospital</u>	# Deaths after <u>Discharge</u>	Mortality <u>Rate</u>
Sutter Solano	1,528	131	We have no way of verifying this information	8.5%

Furthermore, without detailed information concerning the billing data used by HCFA in computing predicted mortality rate, we are unable to verify the accuracy of diagnostic, or other data used in their analysis. Moreover, while HCFA did consider risk of various illnesses and primary diagnoses, they confirmed that their data did not consider the severity or intensity of a patient's illness. It also did not consider the decreased statistical significance of small numbers in a hospital the size of Sutter Solano Medical Center.

There Is More To Be Said

The overall mortality rate of Sutter Solano Medical Center, (even using HCFA's numbers, 17.6% rounded to 18), reflects a higher intensity and severity of patient illness in our community. Why is this so? It can be partly accounted for by the higher percentage of older people living here as opposed to North Solano County or West Contra Costa County as shown below:

OLDER PEOPLE IN OUR AREA

	<u>A G E S</u>		
	<u>65-74</u>	<u>75-84</u>	<u>85+</u>
Vallejo-Benicia	6.9%	3.5%	0.8%
West Contra Costa County	5.7%	2.7%	0.8%
Northeast Solano County	4.5%	1.9%	0.4%

In addition to a large retirement population, our community includes other substantial health risks that contribute to a sicker population:

- Many residents with a higher incidence of chronic untreated illnesses
- Highly industrial community reflecting higher chronic illness incidence
- Disproportionate number of indigent patients, again with higher incidence of untreated illness

Our Own Review of Medical Records

In only one category did the hospital's actual mortality rate fall slightly above the range of predicted rates: Gastrointestinal Disease (bleeding ulcers/intestines). We would have predicted this due to the higher incidence of alcohol-associated chronic illness patients seen in this category. Alcoholics typically present themselves with multiple body system diseases that puts these patients at higher risk.

We also looked at two other categories: patients with severe acute heart disease, and infectious diseases (sepsis). Our findings are as follows:

Heart Disease. Sutter Solano Medical Center's heart program includes extensive medical services and liaison with other Bay Area hospitals that augment our services here, e.g., cardiac catheterization and open heart surgery. Our patients transferred to other hospitals under this category were not included by the federal government in our hospital statistics! This is a substantial flaw in HCFA's counting methods, and gives a very false impression of the total work we do.

Sepsis. More than half the patients in this category typically are nursing home patients who have become terminally ill and are returned to the hospital for their final moments of care. These patients often come to us with a request from patient, family, and physician for normal care with no extraordinary

measures to prevent inevitable death of the patient. We respect those legal, family and medical wishes for "death with dignity", and in this care, consider the result to be part of our overall mission of caring for the patient to the best of our abilities.

In conclusion, our review confirms our patients received appropriate, concerned, high-quality medical care.



TEMPLE COMMUNITY HOSPITAL

October 14, 1987

California Medical Review Inc.
3450 Wilshire Blvd. Suite 1200
Los Angeles, California 90010

To Whom It May Concern:

The Temple Community Hospital (050111) prides itself on the care our patients receive from every member of the medical staff, and every member of the hospital staff. I feel very comfortable that our patients receive the highest quality care possible.

REVIEW OF HOSPITAL MORTALITY DATA WAS REVIEWED AS FOLLOWS:

Patients whose death occurred in a year subsequent to the year of admission, in which there were 3 cases.

1. Age [REDACTED] - Patient with carcinoma of the lung, pneumonia and congestive heart failure. (Terminal Disease)
2. Age [REDACTED] - Patient with septic shock, pneumonia, premature ventricular contractions, seizures, urinary tract infection and complete heart block. (Multiple medical problems)
3. Age [REDACTED] - Patient with severe uremia, on dialysis, squamous cell carcinoma of larynx; pneumonia, pericarditis and cirrhosis. (Terminal disease)

Review of deaths after discharge which there were 6.

1. Error on date of death. [REDACTED] did not expire after discharge. Patient admitted 4/9/86 and expired 4/12/86 while in the hospital.
2. Patient had metastatic lymphoma and had reached optimal level of care for acute hospitalization and was transferred back to an Extended Care facility.
3. Patient refused to have pacemaker inserted for severe Bradycardia and signed out A.M.A.

235 NORTH HOOVER STREET • LOS ANGELES, CALIFORNIA 90004 • (213) 382-7252

MEMBER AMERICAN HOSPITAL ASSOCIATION • CALIFORNIA HOSPITAL ASSOCIATION • HOSPITAL COUNCIL OF SOUTHERN CALIFORNIA
ACCREDITED BY JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

4. Patient with multiple medical problems - Age 95 had reached optimal level of care for acute hospitalization and was transferred back to an Extended Care Facility.
5. Patient had carcinoma and refused any further evaluation or treatment only wanted to die, sent back to an Extended Care Facility.
6. Patient had end-stage renal disease was admitted for dehydration. Her length of stay was 5 days for dehydration. Patient was stable and ambulatory at discharge. The following day while on out-patient dialysis the patient had a cardiac arrest which her physician stated was an acute myocardial, massive, infarction.

Review of deaths under age 65 of which there were seven, 6 of these deaths were patients with end-stage renal disease with multiple organ system disease who are the unfortunate victims of a tragic disease.

Review of deaths in the 65 and over age group have been reviewed by the Medical and Surgical Staff and the following is a brief summary:

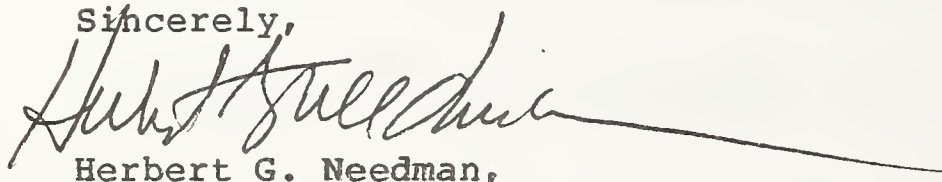
The majority of these patients were admitted from Extended Care Facilities with multiple medical problems. The Medical Staff has taken an aggressive role in reviewing all deaths and are assured that the care delivered was appropriate and physicians implemented corrective procedures when indicated.

On an ongoing basis the medical staff will continue to review deaths that are included in your data so they are prepared to assist us in responding to requests for information as data is released.

Our Quality Assurance Program will place a renewed emphasis on studies that will vigilantly monitor the care being provided in the areas where our death rate appears higher than the State average.

Thank you for the opportunity to present this response.

Sincerely,



Herbert G. Needman,
Administrator/Chief Executive Officer

HGN/jt



**Torrance Memorial Hospital
Medical Center**

Affiliated with Health Access Systems

October 23, 1987

MEDICARE PROVIDER # 050351

Dear Reader,

We are pleased to take this opportunity to contribute additional information about Torrance Memorial Hospital Medical Center which will help with the interpretation of the 1987 HCFA mortality statistics release.

Torrance Memorial Hospital Medical Center is a 330-bed acute care facility. We are a full-service medical center offering care in the specialty areas of cancer, cardiology, open heart surgery, newborn intensive care, rehabilitation services, and burn treatment, as well as general medicine and surgery. The specialty services offered attract a mix of patients with extremely acute conditions which has been validated through comparison of our case mix index with both regional and national hospitals.

HCFA has emphasized that the mortality data does not definitively identify areas in a hospital where "low quality" or "high quality" care is delivered. HCFA suggests that the data should be used principally by hospitals to identify areas that merit additional review. Our Quality Assurance Committee supports this position and it has thoroughly reviewed the mortality cases involved in this study.

It was noted by the committee that while our overall mortality rate was within the predicted range, in the category of pulmonary disease we fell outside the predicted range. We feel the following notes from our Pulmonary Disease case review will be useful in interpreting the statistics.

61% of the patients who died in this category had been transferred to the hospital from nursing homes medically indicating the patients were in a very debilitated state at the time of admission. HCFA's model, that predicted expected mortality, took transfers into consideration

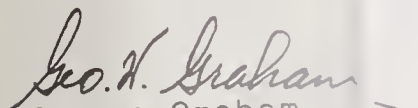
only if the transfer was made within 24 hours of the death. The majority of our patients were not included in this portion of the model's parameters and thus a higher mortality rate would be anticipated.

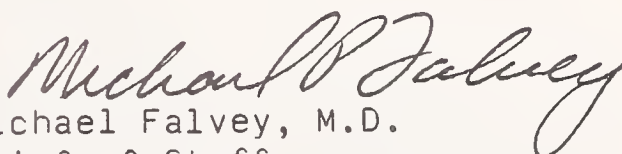
- In many cases death was considered to be a significant possibility or the expected outcome at the time of admission. In 65% of the mortality cases the physician consulted with the patient and/or the family regarding the stage of the disease and it was agreed to support the patient's wishes that no extraordinary efforts or intensive treatment would be undertaken if death was imminent; these patients had a "Do Not Resuscitate" order on their chart. This factor would increase the mortality rate.
- 93% of the cases in this category that resulted in death had an unusually large number of complicating diseases in addition to the pulmonary diagnosis. This impacts the statistics in the following way; Pneumonia may have been listed as the reason for admission, but, quite often the cause of death was related to one of the other conditions, such as cancer. This reporting practice will artificially inflate certain categories.
- 31% of these patients had an additional diagnosis of cancer. HCFA's model considered cancer as a co-morbidity, but, there was no method to measure the intensity of the illness or how advanced a state the cancer had reached. Because we operate an oncology unit, we specialize in the treatment of patients with terminal conditions and it is quite likely that we would experience a higher than average mortality rate.
- 29% of the patients in this category expired AFTER discharge from this facility and we are unaware of the cause of death. It may have been anticipated at the time of discharge or totally unrelated to the hospital admission.

We are confident after this thorough review that we have continued to uphold our very high standards of care. The hospital's Medical Staff has made a conscientious effort to review and monitor the care and treatment delivered in all of the hospital departments; it has appointed a Quality Assurance Committee to oversee this important function. One integral aspect of the committee's role is the intensive review, by physicians, of the medical record of every patient who has expired at this facility, to assure the medical management was appropriate. The Joint Commission on Accreditation of Hospitals has surveyed our facility, examined our quality assurance initiative, and granted us accreditation indicating we have high quality standards.

If the reader would like additional information about TMHMC or assistance with interpreting HCFA's findings, please feel free to contact Mark Costa, Vice President/Administration at the Medical Center. We have a commitment to delivering comprehensive, compassionate and quality care and we would be happy to discuss our programs, our goals, and our quality monitoring activities in greater detail.

Sincerely,


George Graham,
President


Michael Falvey, M.D.
Chief of Staff

1458S:K

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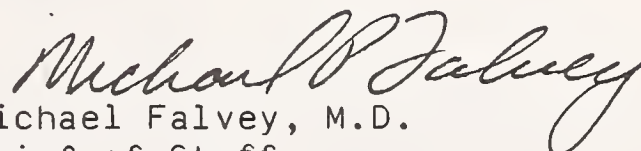
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Sincerely,


George Graham,
President


Michael Falvey, M.D.
Chief of Staff

1458S:K



Tri-City Medical Center

4002 Vista Way, Oceanside, California 92056, (619) 724-8411

Richard A. Hachten II
Chief Executive Officer

October 22, 1987

Medicare Provider #:	Acute Inpatient:	050128
	Rehabilitation:	05T128
	Mental Health:	05S128

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

RE: 1986 Hospital Mortality Information

The opportunity provided by the Health Care Financing Administration (HCFA) for hospitals to review and comment on the 1986 mortality data is greatly appreciated. Tri-City Medical Center is encouraged by the efforts of HCFA to improve both the model for predicting hospital mortality rates and the process for releasing mortality data to the public.

As the principle health care resource in north coastal San Diego County, Tri-City Medical Center is committed to the ongoing education of the general public. Consequently, the release of the 1986 mortality data is viewed as an additional opportunity to inform the general public regarding the high quality of care that is provided at Tri-City Medical Center.

The 1986 HCFA data shows Tri-City Medical Center to be well within the predicted ranges of mortality for each major diagnostic group. However, this is not considered to necessarily be a reflection on the quality of care provided in the Medical Center. Rather, the quality of care is insured through an ongoing, comprehensive review process that continually monitors and insures the provision of high quality health care services. The overall mortality, as predicted and as measured by HCFA, is a single variable to be considered in this process. The HCFA mortality data, on it's own, is not representative of the quality of care that has been provided in a hospital setting.

To insure the appropriate interpretation of the HCFA data, considerable effort has been extended to validate the accuracy of the data prior to public release. Unfortunately, the accuracy is extremely difficult for a hospital to validate. Significant factors that contribute to this situation include:

- The use by HCFA of deaths that have occurred outside the hospital setting. Once a patient leaves the hospital environment, it is extremely difficult to determine whether or not a death has occurred and if, in fact, the death is associated with the care provided.
- The model does not make specific accommodations for specialized high risk services such as a major oncology program, neurosurgery and cardiovascular surgery.
- The overall severity of a patient's illness continues to not be fully accommodated.

The HCFA data, considering the limitations such as the factors noted above, does provide a reasonable approximation of the actual mortality statistics of Tri-City Medical Center.

Setting the limitations of the HCFA data aside, the data is useful as an adjunct to the existing quality assurance process at Tri-City Medical Center. This process reviews the care provided to every patient admitted to the Medical Center. Many parameters of care are evaluated including variables such as complications to treatment, the appropriateness of a specific therapy, the timeliness of treatment and mortality. This very thorough review process is performed by the medical staff in a peer evaluation format that identifies problems so immediate and appropriate corrective action can be taken when necessary.

Tri-City Medical Center will continue to pursue its commitment to excellence of which an integral part is the ongoing evaluation of service quality. A central part of this commitment is to continue an active role in providing accurate and meaningful information to the public in regards to the quality of care provided. The Medical Center looks forward to continue working actively with the health care industry and with HCFA to further improve the accuracy, usefulness and understanding of mortality information.

Any individuals wishing to ask further questions about the Tri-City Medical Center mortality data are encouraged to contact Richard A. Hachten, II, Chief Executive Officer, telephone number (619) 940-3348, Tri-City Medical Center, 4002 Vista Way, Oceanside, California, 92056.

Sincerely,


Richard A. Hachten, II
Chief Executive Officer

RAH/dd
8:66



Box 1229
P. O. ~~XXXXXX~~
Weaverville, California 96093
(916) 623-5541

October 26, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Health Care Consumer:

The following information for Trinity Hospital is to be attached to the Hospital specific report for the period of January 1, 1986 through December 31, 1986 prior to public disclosure.

Trinity Hospital is an acute care facility dedicated to rural healthcare who serves patients in the areas of skilled nursing and chemical dependency as well as medicine and surgery.

Our hospital Medical Staff monitors every death in our facility on an ongoing basis. We believe that our monitoring system provides us with a continuous feedback mechanism in an effort to continue to meet and exceed quality care standards.

Since receiving this data, the professional staff at Trinity Hospital has had an opportunity to review the data. Our overall percentage of deaths is in the lower half of the range of predicted mortality rates. In reviewing the mortality rates by diagnostic category, it is noted that with the small amount of discharges in each category at Trinity Hospital even on fatality can create a very high percentage of deaths in one specific category.

Our Medical Staff will continue to review all mortality cases for quality and appropriateness of care rendered to the individual patient as part of our quality assurance and peer review process.

Thank you for the opportunity to present this response.

Sincerely,

TRINITY HOSPITAL

Patricia Menning
Patricia Menning
Administrator

Ed Dolci MD
Edward L. Dolci, MD
Chief of Staff

CA 477



TwinCitiesCommunityHospital

1100 Las Tablas Road
Templeton, California 93465
(805) 434-2813

October 22, 1987

William L. Roper, M. D.
Administrator
Department of Health & Human Services
Health Care Financing Administration
The Administrator
Washington, DC 20201

Dear Doctor Roper:

Having had an opportunity to review the mortality data information to be presented to the public, I would like to take this opportunity to make several comments:

1. Our records indicate a total of 1,303 Medicare admissions in calendar year 1986 whereas your records show 880 Medicare Admissions. When using this 1,303 Medicare admissions number in the calculation of mortality, our overall mortality rate then becomes 8% instead of the 12% your study shows.
2. This represents roughly a 48% difference. This discrepancy in the number of admissions adversely affects mortality information for our hospital.

While it is appreciated that H.C.F.A. is doing its best to improve the quality of the mortality data that it releases by taking into account chronic underlying or co-morbid conditions, the inclusion of patient deaths occurring within 30 days of discharge is both misleading and unfair to hospitals.

For our hospital a total of 21 deaths were included in our overall mortality data occurring post discharge. If these deaths were subtracted from our mortality data based on the number of Medicare admissions that our records show we had, our overall mortality rate would be 6% instead of 12%.

The attribution of these deaths to the discharging hospital does not take into account deaths that are unrelated to the condition that the patient was under treatment for at the time of discharge. Additionally, it fails to take into account the many patients who rightfully choose to die in their own homes. The whole basis of having Hospice and extended home-care programs is to provide the terminally ill with options other than death in the acute care hospital setting.

HCFA/EXEC.SEC.

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October 22, 1987

Page 2

Finally and most importantly, the hospital has no control over the management of the patient at home or in the post-acute facility.

It is our hope that H.C.F.A. will further refine its reporting of statistical mortality data and exclude any deaths after a patient is discharged from the hospital as it is a totally unreliable indicator of a facility's ability to provide adequate quality of care. The only way mortality data of any kind can be used as an indicator of the delivery of quality patient care is by individual case-by-case analysis done within the appropriate medical staff committees. We conduct such reviews on an ongoing basis in our facility and will continue to do so with or without an outside mandate because as health care providers, we believe it is our duty to monitor our own quality of care and to take responsibility for it.

Sincerely,



Barry A. Wolfman,
Chief Executive Officer

BAW/cj

cc: Neil Sorrention, Senior VP Operations, NME



OFFICE OF THE DIRECTOR
UCLA MEDICAL CENTER
CENTER FOR THE HEALTH SCIENCES
LOS ANGELES, CALIFORNIA 90024
October 23, 1987

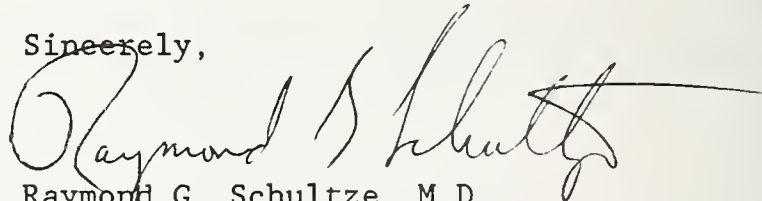
William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for the opportunity to respond to the 1986 mortality data for UCLA Medical Center (Medicare Provider number 05-0262).

The mortality rates for all 16 specific disease categories fell well within the range of predicted mortalities. Furthermore, the overall mortality rate for UCLA Medical Center was below the lower bound established by the HCFA model. We are gratified that this data confirms the high quality of patient care provided at our institution. However, we remain skeptical about the validity of the HCFA methodology. Although several issues regarding the model remain unclear, of particular concern is the absence of an adequate adjustment for differences in severity of illness between patients in the same disease category. As a university teaching hospital and major referral center, we believe that our patients represent the most severely ill spectrum of many disease categories. Until the HCFA data can account for severity of illness, the information will be difficult to interpret and meaningless for the purpose of encouraging educated consumer choices.

Sincerely,



Raymond G. Schultze, M.D.
Director

RGS:DMA/cgl

UKIAH ADVENTIST HOSPITAL

275 HOSPITAL DRIVE • P. O. BOX 859 • UKIAH, CALIF. 95482 • 707 462-6631

October 26, 1987

William L. Roper, M.D., Administrator
Department of Health & Human Services
Health Care Financing Administration
Washington, D.C. 20201

Dear Doctor Roper:

RE: 1987 HCFA Mortality Rate Report
Ukiah Adventist Hospital ID #050301

Ukiah Adventist Hospital appreciates the opportunity to provide a written response in advance of the publication of the Mortality Rate Report by the Health Care Financing Administration.

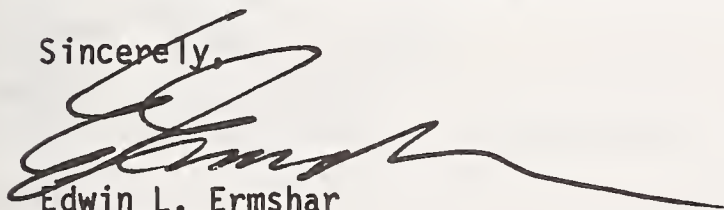
Ukiah Adventist Hospital takes the matter of quality in healthcare very seriously. The Medical Staff of Ukiah Adventist Hospital conducts an intensive review of the medical record of every patient who expires at this facility. This peer review is an integral part of our Quality Assurance program; therefore, the statistics provided by HCFA are already known to us.

It is worthwhile to note that our overall mortality rate is at the low range of the predicted mortality rate. We would also like to point out that the actual mortality rate is well within the range of predicted mortality rates in each of the categories listed. Even though these statistics do not take into account the severity of the patient's illness at the time of admission, we feel that our commitment to quality care for our patients is reflected in these statistics.

While there may be some difficulties inherent in using mortality rates as a measure of quality in healthcare, we applaud the effort to provide the American public with reliable information on this important industry. We trust the above information has served to further this effort.

If you have any questions about our section of the HCFA report or the above information, please feel free to contact me.

Sincerely,



Edwin L. Ermshar
President



William Bowen, M.D.
Chief of Staff

HCA Ukiah
General Hospital

October 23, 1987

William C. Roper, M.D.
DEPARTMENT OF HEALTH &
HUMAN SERVICES
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for the opportunity to respond to HCFA's current release of data on hospital mortality rates.

Upon receiving the report last month we have reviewed the information. With a few minor variations we have confirmed the data is accurate and reflects the statistics at our facility.

Our overall mortality rate of 15% compares favorably with the 10%-19% range of predicted mortality rates. The mortality rate in one category is slightly greater than the predicted range.

Since we are a 45 bed rural hospital the number of patients in any particular admitting diagnosis is small. One death in any diagnostic category can have a significant impact on our mortality rate for that category.

Our hospital performs an ongoing review of patient care to assure an appropriate level of service is delivered. The Tissue/Mortality/Morbidity/Blood Committee reviews every death occurring in the hospital. The Quality Assurance Committee reviews the quality of care provided. These committees, consisting of physicians, nurses, and other health care professionals place an emphasis on studies relating to direct patient care.

We will continue our commitment to the community and our patients. Thank you for the opportunity to present this response. Should you or anyone have any questions, please feel free to contact us at (707) 462-3866.

Sincerely,


Kelly C. Morgan
Administrator

KCM/dlp

cc: M. Jane Thomas
Hospital Council of Northern California

1120 So. Dora Street
P.O. Box 3900
Ukiah, California 95482
Telephone (707) 462-3866
A subsidiary of HCA The Healthcare Company

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

UNIVERSITY OF CALIFORNIA, IRVINE

BERKELEY • DAVIS • IRVINE • LOS ANGELES • RIVERSIDE • SAN DIEGO • SAN FRANCISCO



SANTA BARBARA • SANTA CRUZ

OFFICE OF THE DIRECTOR
CLINICAL SERVICES
October 23, 1987

MEDICAL CENTER
101 THE CITY DRIVE
ORANGE, CALIFORNIA 92668

William L. Roper, M.D.
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

RE: **Medicare Provider Number: 050348**

Dear Dr. Roper:

We have reviewed the HCFA Medicare Mortality Data Report for 1986. We have the following conclusions:

- UCI Medical Center is within the expected mortality range for all categories.
- UCI Medical Center is a tertiary Burn Center as well as a Trauma Center. Four of the six deaths in the severe trauma category were severe burn cases.
- In the area of cerebrovascular accidents, 78% of the CVA patients were over 65 years of age with multiple medical problems.

All deaths are reviewed at UCI Medical Center by our Quality Assurance Program and medical staff departments/committees. Our overall mortality rate remains relatively low at 1.6%.

UCI Medical Center will continue to offer the highest quality of care to all patients.

If you have any comments regarding our response, please contact Larry Stahl, Assistant Director, at (714) 634-5676.

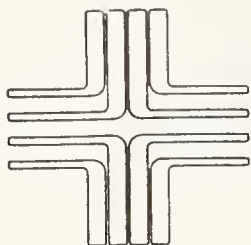
Sincerely,

A handwritten signature in dark ink, reading "Walter L. Henry" with a stylized flourish at the end.

Walter L. Henry, M.D.
Chair, Executive Committee of the Medical Staff

WH/LS/jms

cc: Leon M. Schwartz, Director, Hospital and Clinics
David Powers, M.D., Chair, Utilization Review Committee
Larry A. Stahl, Assistant Director



UCSD
MEDICAL CENTER
University of California, San Diego,
Medical Center

225 Dickinson Street
San Diego, CA 92103

Office of the Director

October 27, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Department of Health & Human Services
Washington, D.C. 20201

Re: Hospital Selected Mortality Information
University of California, San Diego Medical Center
Medicare Provider Number 05-0025

Dear Sir:

I am writing to request that a copy of this letter be included with the final publication of UCSD Medical Center's mortality information.

The UCSD Medical Center is a teaching hospital associated with the School of Medicine, University of California, San Diego. The Medical Center is a tertiary care facility with a Regional Burn Center, Level I Trauma Center, licensed comprehensive Emergency Medical Services, Level III neonatal unit, and Level III Perinatal Services. Further, we have a number of specialty services, including Pulmonary Critical Care, Stroke Unit, Cancer treatment, etc. Because of the level of services available here, we generally admit and treat high-risk, seriously ill patients who may have multiple traumatic injuries or multiple medical problems. A number of these patients may expire from underlying or concomitant conditions other than the "principal" condition which necessitated hospitalization.

Our records indicate that 2,964 Medicare admissions occurred in 1986. Presumably, the discrepancy between HCFA's count (2,459) and ours reflects multiple admissions of individual beneficiaries.

The overall mortality rate for UCSD Medical Center (9%) was in the low end of the range of HCFA's Predicted Mortality Rates (7 to 14%). Of the ten High Risk Diagnostic Categories, UCSD Medical Center fell below the Predicted Mortality Rate in two categories and within the range for seven of the categories. Only in the Severe Trauma Category did the Medical Center fall outside the predicted range, which is understandable given that we are the Level I Trauma Center for San Diego County. Therefore, we have a far greater proportion of the traumas in San Diego and, of the traumas, the more severe cases.

October 27, 1987

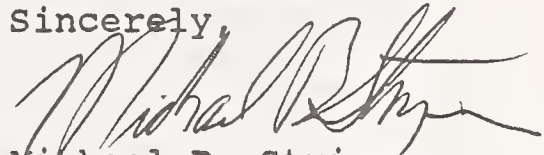
Page 2

The HCFA data indicated that a total of 134 Medicare patients admitted to the Medical Center expired within 30 days of admission. Of these, 112 patients expired while still a patient of the Medical Center, while 22 (or 16.4%) expired after discharge. Thus, HCFA's mortality data may be overstated for our institution to the extent that it includes patients who expired after discharge which may or may not be related to the hospital admission. We seriously question HCFA's inclusion of post-discharge deaths in their mortality data until such time that it is possible to have data made available that can relate the deaths to the respective reasons for hospitalization.

It should be pointed out that UCSD Medical Center's mortality data is also affected by a high percentage (83 of the 112 hospital expirations or 74.1%) of patients in the High Risk Category. Further, 14 of the 112 patients (or 12.5%) were transferred from other hospitals to UCSD Medical Center.

Overall, however, we believe the HCFA data reflect the practice of excellent patient care at UCSD Medical Center.

Sincerely,



Michael R. Stringer
Director
Hospital and Clinics

Office of the Director
Moffitt 181
San Francisco, CA 94143-0208
415/476-1401

The Medical Center at the University of California, San Francisco



Herbert C. Moffitt Hospital
Joseph M. Long Hospital
UCSF Children's Medical Center
Langley Porter Psychiatric Hospital
Ambulatory Care Center
Herbst Emergency Service

October 21, 1987

William L. Roper, MD
Administrator
Department of Health & Human Services
Health Care Financing Administration
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

On behalf of the Medical Center and Medical Staff at the University of California, San Francisco, I am writing in response to HCFA's planned December 1987 release of hospital-specific mortality information on Medicare patients treated during calendar year 1986. Please accept our appreciation for the opportunity to review and comment upon the data prior to the release.

We understand and are in full support of the desire of the Health Care Financing Administration to provide the public with useful tools for evaluating the quality of care provided by individual institutions; additionally, we are in support of the goal of analyzing whether or not changes in the Medicare payment system have led to a change in the level of care provided to Medicare patients. As the release of hospital-specific mortality statistics represents a step in the direction of these two objectives, we respect and support the effort. We have, however, serious reservations about the usefulness of mortality data by themselves as measures of quality, reservations which we have previously communicated to California Medical Review, Incorporated, upon its quarterly releases of mortality statistics. It is our conviction that mortality statistics must, in order to have validity in any comparisons between institutions, include severity or case-mix adjustments reflecting accurately each institution's actual patient population.

Notwithstanding the limitations of mortality statistics as indicators of quality of care, our Medical Staff has for a number of years found such data to be of great value in suggesting areas for peer review. Each death that occurs in our hospital is first reviewed within the clinical department responsible for the patient; in the case of many of our larger departments, this review is preceded by a review within the subspecialty division of that department. Each death is also independently reviewed by the Surgical Case and Hospital Mortality Review Committee, a standing committee of our Medical Staff, which is charged with monitoring whether or not the treatment provided to these patients was within appropriate standards of care. This Committee reports on its reviews on a monthly basis to the Quality

William L. Roper, MD
October 21, 1987
Page 2

Assurance Executive Committee, and also refers to that Committee any issues calling for follow-up action or further review. Finally, should the results of any of these reviews identify an individual physician whose performance is deemed to be unacceptable, immediate reporting is made to the Credentials Committee of the Medical Staff for appropriate action. The consideration of quality assurance information by the Credentials Committee is of highest priority, and actions to limit individual practice and assure quality of care are taken as deemed appropriate.

The goal of all of these review processes, and indeed the paramount objective of the Medical Staff organization, is to assure that the quality of care provided to patients of the institution is of the highest possible quality. Although mortality statistics do serve as a guide for review of the performance of individual practitioners as well as a suggestion for in-depth investigation of particular interventions, there are many situations in which the statistics alone do not give an appropriate evaluation of the quality of care with respect to either the individual practitioner or the institution. For example, an institution which performs a high-risk procedure on a high-risk patient population, with a relatively low volume of procedures, may experience a mortality rate which appears to be relatively high; this statistic, however, will not reflect anything about the quality of care actually provided. What is needed is an analysis of variables that can accurately be said to define high-risk populations or severity-of-illness, so that the use of mortality statistics as measures of quality can be actually meaningful.

With respect to the data incorporated in the HCFA release, both the Medical Staff and the Medical Center conducted a careful review of the findings and their potential implications. Each death was first validated with our records, and while a few discrepancies were present, they were not found to be of significance. Each in-hospital death had already been reviewed by the clinical department responsible for the patient, and the results of these reviews documented within that department's quality assurance records; additionally, each death had already been reviewed by the Surgical Case and Hospital Mortality Review Committee, and reported to the Quality Assurance Executive Committee.

While our actual mortality rates were at the low end of the range of predicted rates in 14 of the 16 diagnostic categories reported by HCFA (and below the range in the 15th), our rate in the category of sepsis was at the middle of the range (57%). In spite of the low number of cases falling into this category, the category had been investigated earlier following prior releases by CMRI of mortality statistics, and was found to include patients who were brought into

William L. Roper, MD
October 21, 1987
Page 3

our emergency department in terminal condition and who expired within 24 hours of admission as well as others who were critically ill at time of admission with diseases such as end-stage renal disease and terminal leukemia. Given this analysis, our Medical Staff is comfortable that the deaths reflected in this category were unavoidable and not indicators of a quality of care problem.

In conclusion, our Medical Staff and administrative staff are committed to the review of deaths as a critical mechanism of quality assurance peer review. Additionally, we are in strong support of the need for models for evaluating overall hospital quality, and are working ourselves, as are the American Hospital Association and the Joint Commission on Accreditation of Hospitals, on developing such tools for use by the public. We would be eager to cooperate with the Health Case Financing Administration on efforts to refine current analytical methodologies in order to develop more meaningful models.

Sincerely,



William B. Kerr
Director
Medical Center

WBK/jah

cc: J. R. Krevans, MD
R. Schmid, MD
S. G. Kramer, MD
S. Lindenfeld, MD



Valley Hospital
Medical Center

14500 Sherman Circle
Van Nuys, California 91405
(818) 997-0101

October 27, 1987

Provider #050299

William Roper, M.D.
Administrator
Department of Health and Human Services
HealthCare Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

Pursuant to the release of HCFA Mortality Data, find below comments related to the statistics reflected for Valley Hospital Medical Center. Please feel free to contact me at your convenience with any questions or for clarification.

HCFA MORTALITY DATA RELEASES - 1986

All hospital deaths have been reviewed for diagnostic and therapeutic appropriateness by physicians as a function of the hospital's Quality Assurance Program. The Quality Assurance Program entails ongoing monitoring and review of hospital care, attempting to continually improve the medical care provided to our community.

From our mortality reviews we have learned that the most frequent predictor of hospital death is impairment of the patient's health with chronic terminal diseases to such an extent as to have made it necessary (1) for the patient to have resided for a considerable time in a nursing home prior to admission to the hospital and (2) for the patient's family to have requested that no heroic measures be taken to further prolong life.

Sincerely,

Richard D. Lyons
Chief Operating Officer/Administrator

RDL:bar



Valley Medical Center

October 23, 1987

Karen Logsdon
Senior Vice President
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Dear Ms. Logsdon:

Thank you for the opportunity to respond to the release of data on Valley Medical Center's hospital mortality rates for 1986.

Since receiving the report the first of this month we have verified the accuracy and have reviewed the records in the diagnostic category of cerebrovascular accidents and pulmonary disease. In each of these categories our actual mortality rate was 4% and 2%, respectively, above the range of predicted mortality rates. All deaths, in all financial codes, are reviewed by the appropriate departments on a monthly basis. This is an integral part of our quality assurance program.

Reviewing the statistics, it is readily apparent that all the patients except one were admitted with multiple systems problems and high severity of illness. A small percentage were in their 60's and 90's, but the majority were in their 70's and 80's. The review of these deaths revealed that the care was appropriate and timely.

Mortality rates at Valley Medical Center are impacted in part because we are a county teaching hospital and a referral center for many services, including pulmonary and cerebrovascular problems. This, plus Central Valley Hospice, located in VMC, account for the large number of acutely ill patients that are admitted. Our mortality rate does not seem to be inconsistent with the population and the disease entity.

Valley Medical Center supports the principle of communicating appropriate quality of care issues to consumers and we welcome the opportunity to discuss the quality of care and services.

Sincerely,

A handwritten signature in dark ink, appearing to read "Jimmy M. Knight".

Jimmy M. Knight
Associate Administrator and
Chief Operating Officer

JMK/OCS/jb

2794D

1111 East Stanley Boulevard
Livermore, CA 94550
415/447-7000



October 22, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

RE: HCFA 1986 Mortality Data Release
for Valley Memorial Hospital, Livermore, CA.
Medicare Provider #: 05-0283

Dear Sirs:

Valley Memorial Hospital appreciates the opportunity to review and comment on our 1986 Medicare mortality data.

Our review process indicates that all admission and discharge dates of patients credited to Valley Memorial Hospital are correct: however, our records reflect that [REDACTED] was actually readmitted to our facility on 7/29/86 and expired on 8/6/86, rather than on 7/25/86 as shown in your data.

Enclosed please find the comments which we wish to be appended to our hospital-specific data prior to public disclosure.

Thank you.

Sincerely,

A handwritten signature in dark ink, appearing to read 'Robert H. Fish', is written over the word 'Sincerely,'.

ROBERT H. FISH
PRESIDENT AND CHIEF EXECUTIVE OFFICER

RHF:s1

1111 East Stanley Boulevard
Livermore, CA 94550
415/447-7000



October 22, 1987

To Whom it May Concern:

The following comments may assist in your review of the 1986 Medicare mortality data for Valley Memorial Hospital.

Valley Memorial Hospital is a 110-bed acute care facility, offering care in the specialties of cardiology, digestive disease, respiratory ailments, orthopedics, neurology/neurosurgery, obstetrics/gynecology and pediatrics, as well as general medicine and surgery.

A review of the summary table describing our data indicates that Valley Memorial Hospital's mortality rate for each of the sixteen diagnostic categories as well as for the total sample, fell within HCFA's predicted range.

The records of each patient expiring in our facility are reviewed for appropriateness of care as part of Valley Memorial Hospital's on-going Quality Assurance Program. We have verified that each of the Medicare mortality cases have been referred to the appropriate Medical Staff department or committee for review. This peer review activity is an integral part of our continuing commitment to identifying opportunities to improve patient care.

Sincerely,

A handwritten signature in dark ink, appearing to read 'Robert H. Fish', is written over the typed name.

ROBERT H. FISH
PRESIDENT AND CHIEF EXECUTIVE OFFICER

RHF:s1

NU MED REGIONAL MEDICAL CENTER - WEST VALLEY

October 20, 1987

Dear Mr. Roper;

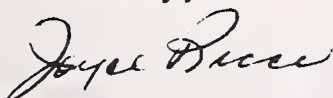
Thank you for the opportunity to respond prior to the release of the mortality data pertaining to Valley Park Medical Center.

For many years Valley Park Medical Center provided Hospice care to terminally ill patients. Coding guidelines, under the Prospective Payment System, required that the hospital code the reason for admission. In the case of many cancer patients the reason for admission was the pain rather than the underlying cancer. These guidelines for coding were revised in mid 1986.

The data for Valley Park Medical Center classifies only seven (7) patients in the cancer category. A review of medical records reveals that twenty-one (21) patients expired in the Hospice unit of cancer. Seven (7) of these patients are classified in the other conditions category, three (3) are in the orthopedic category, three (3) are in the metabolic conditions category and one (1) is classified in the gastrointestinal category.

I thank you once again, for the opportunity to clarify this data.

Sincerely,



Joyce Ricci, ART
DRG Coordinator

Valley Presbyterian
HOSPITAL

15107 Vanowen Street
P.O. Box 9102
Van Nuys, CA 91409-9102
(818) 782-6600



October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
P.O. Box 26684
Baltimore, Maryland 21207

Dear Doctor Roper:

We appreciate having the opportunity to respond to the release of data regarding our 1986 mortality statistics.

Valley Presbyterian Hospital is a 331 bed acute care facility. We provide a full range of general services as well as many specialized services, including oncology, cardiology, open heart surgery, orthopedic services and a 32 bed skilled nursing unit.

The medical staff committees conduct an in-depth review of every death that occurs within their department to insure that appropriate high quality of patient care was provided each patient. The results of these studies are incorporated into our Quality Assurance program to insure that the quality and appropriateness of care being rendered at Valley Presbyterian Hospital is being continuously monitored.

The hospital specific mortality data has been carefully reviewed by the hospital's Administration, the Chief of Staff, the Chairman of Utilization Review Committee and other appropriate committees of the medical staff.

Our analysis of the data reveals that in each diagnostic category the actual mortality rate for Valley Presbyterian Hospital was well within the range of predicted mortality rates. We did however conduct an in-depth review of all cases where the death occurred following discharge from the hospital to determine 1) if the discharge was premature and 2) that the patient received discharge planning services.

Arthur D. Aston
Chairman of the Board

Robert C. Bills
President

David W. Fleming
Vice Chairman

Richard H. Dunn
Vice President

Howard E. Shirley
Vice President

Thomas W. Clarke
Secretary

James E. Lombardo
Treasurer

William L. Roper, M.D.
October 23, 1987
Page (2)

Sixty-five medical records were reviewed. There was no evidence of premature discharge and 55 (85%) of the patients had received discharge planning services and were referred to skilled nursing facilities or to home health agencies.

Again thank you for the opportunity to present this response.

Sincerely,



Robert C. Bills
President and
Chief Executive Officer

RCB/SR/NS/eb



Stanley Rossman, M.D.
Chief of the Medical Staff

Van Nuys Community Hospital

October 28, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper,

We have reviewed the mortality statistical information you have provided on Medicare admissions in 1986 and have found that the number of admissions you have stated (294) differs greatly from our records (471) which significantly alters the actual mortality rate of 25% to 15%.

In addition, there were twenty (20) of the seventy three (73) listed deaths that did not occur in our facility.

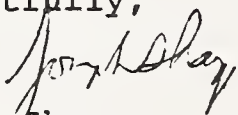
The majority of these patients were referred to us from an extended care facility and were on a "No Code" status.

Please note that:

- * 97% of those deaths listed were over the age of 65
- * 91% were over the age of 70
- * 67% were over the age of 80
- * 27% were over the age of 90

Also, our Medical Committee reviews 100% of all mortalities to ensure that all therapeutic, diagnostic and supportive patient care measures are provided appropriately and adequately.

Respectfully,


Joseph Sharp
Administrator

JS:cb



Associated with the UCLA School of Medicine

A Division of the Ventura County Health Care Agency

October 23, 1987

Health Care Financing Administration
William Roper, M.D.
Administrator

Dear Dr. Roper;

We appreciate the opportunity to comment on the mortality data for 1986, which has been provided us by your offices. These reports are greatly appreciated, as they give us the means to compare our own data and quality assesment mechanisms, while also providing us a statistical comparison heretofore not possible.

In our analysis we have ascertained that the data, as reported, is essentially correct. We were aware of all the deaths listed, with the exception of some of those who died after leaving the hospital, and all in-hospital deaths had already been reviewed by the appropriate committee of our medical staff.

We have now reviewed deaths of ALL these patients, and note that the VCMC rates generally fell within the predicted ranges prepared by your report. This reaffirms our previously held view that the care provided at the VCMC is of high quality.

In one area, that of sepsis, the data indicated a 100% mortality, somewhat greater than the "predicted" range. We have reviewed the five (5) cases, and found the following:

These were cases of patients aged 98, 96, 91, 80 and 78 years, respectively. Each one was very ill, and each hospitalization was for severe and non-curable problems. Sepsis, or severe infection, was the known diagnosis, and all treatments were appropriate and timely. We feel our medical staff, in handling these patients, performed excellent service in the face of overwhelming disease.

As regards the statistical comparison, the small number of cases, (5), really precludes any further evaluation.

Again, thank you for the opportunity to review, as well as comment on these data. We know that the task of adequately evaluating such issues is difficult, and look forward to further refinement of the techniques, as well as interpretation of the results. At the VCMC we are committed to quality care of our entire population, and these studies help us to confirm that commitment.

Sincerely,


John Puryear
Hospital Administrator

encl: HCFA Data Release

3291 Loma Vista Road, Ventura, California 93003, (805) 652-6058

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

VERDUGO HILLS HOSPITAL



1812 Verdugo Boulevard
P.O. Box 1431
Glendale, California 91209
818/790-7100

October 26, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

RE: MEDICARE PROVIDER NUMBER 050124

Gentlemen:

Our review of the HCFA statistical data received on September 24, 1987 notes several discrepancies in the data that must be commented upon.

First of all Verdugo Hills Hospital had 2,347 Medicare discharges in the calendar year 1986, which is the same period of time covered by the HCFA data. However, HCFA only lists 1,524 Medicare discharges. The 823 difference in discharges occurs because HCFA only counts the last admission of these persons, who obviously had more than one additional discharge during that calendar year.

The mortality rate that HCFA is attempting to ascribe to our facility included deaths which occurred 30 days after the patient was last in our hospital. There is no way for us to know, nor for HCFA to know, what the cause of death was. It may or may not have been related to the diagnosis for which the patient was cared for in Verdugo Hills Hospital. We know that 186 Medicare deaths occurred in the hospital, attributable to the disease for which the patient was admitted. HCFA ascribed a total of 232 deaths to Verdugo Hills Hospital, therefore statistically 46 deaths occurred after the patient was discharged, to which we do not have any reasonable means of knowing why the death occurred. According to HCFA methodology, a post discharge death by automobile accident, could be ascribed to Verdugo Hills Hospital, which demonstrates the gross statistical base upon which HCFA is attempting to disclose this information. Although their attempt is laudable, we find the statistics to have many discrepancies. We find six dates of death in error, one patient was listed as dying in the hospital when the patient was in fact discharged alive. One patient listed we could find no such evidence of that patient ever being admitted to Verdugo Hills Hospital.

It is quite understandable when HCFA deals in such mass amounts of statistical data, that errors are bound to occur. But, when that data is being put forth and being touted as being factual and a base upon which community citizens are to evaluate a measure of care or quality of services, it seems an extremely weak methodology for the public to rely upon.

Continuing the tradition of non-profit health care for the community.

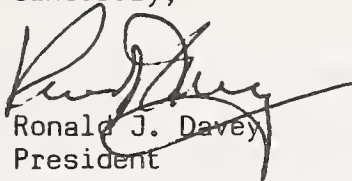
VERDUGO HILLS HOSPITAL

HCFA Standards & Quality Bureau
October 26, 1987
Page two

Verdugo Hills Hospital prides itself in the quality and professional care that we render to our patients, and the confidence that our community can have and does have in the services we render for them. When HCFA eventually develops a severity of illness index which applies to each and every patient and statistical information correctly counted and without error, then we can buy into the disclosure of such information as being worthwhile.

Until that occurs, disclosure of such data on the gross basis that HCFA is currently using, is misleading, distorted and inappropriate.

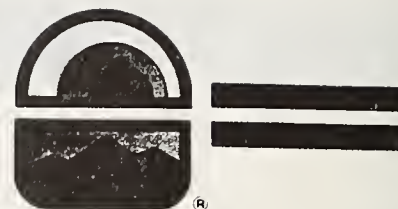
Sincerely,


Ronald J. Davey
President

RJD:mc

VILLAVIEW COMMUNITY HOSPITAL

P.O. Box 5587/5550 University Avenue/San Diego, California 92105-0127/(619) 582-3516



October 23, 1987

William L. Roper, M.D.
Department of Health & Human Services
Health Care Financing Administration
The Administrator
Washington, D.C. 20201

Dear Dr. Roper:

In accordance with your instructions regarding the mortality data, VillaView has reviewed the information that HCFA has generated, which gives rates for deaths of patients, overall and in 16 different diagnostic categories.

The following comments were made after a review of the material and a comparison with our own records.

We have noted that in your listing of patients, HCFA has identified one of our patients as having died the day after discharge. According to our records, this information is incorrect; the patient died in the hospital.

We would also like to comment that we feel that information, such as that being published by HCFA, must include a warning to caution the public regarding the limits to which such data can be utilized in deciding if mortality rates reflect the quality of care that hospitals are providing. Statistical analyses are useful only as a screen for further review.

Quality judgements can only be made after reviewing the information contained in a patient's medical record. Our physicians do review each death record during committee meetings of their peers. Measures are taken when these reviews indicate that there may be a quality issue identified. Accreditation by the Joint Commission on Accreditation of Hospitals and Health Organizations and the California Medical Association also monitor our progress in this area. The further review performed by the Professional Review Organization (PRO) provides us with useful educational tools to help us maintain a high level of quality of care. VillaView's Governing Board, Administration, and Medical Staff all participate in the maintenance of high quality of care.

-continued-

Letter to William L. Roper. M.D.
October 23, 1987
Page 2

Specific to the review of the statistical data for VillaView Community Hospital, we would like to make the following comments.

HCFA only uses Medicare patients who died within 30 days of admission as a criteria, which means that all other patient population and deaths are excluded. An overall death rate for our Medicare population drops from 15% to 8% when we add the rest of the patients listed by the hospital as Medicare beneficiaries who died, regardless of the date of admission.

VillaView did not exceed the range of predicted mortality rates.

The average age of Medicare beneficiaries who died in our facility was 80 years old. We feel that our population of very frail, elderly patients needs to be considered when evaluating mortality data. In each of these patients' records, there was documentation of secondary diagnoses that were also in the high risk category.

One patient in the low risk category of genitourinary disease was actually admitted for urinary complications of cancer and was not expected to live. Exceptions such as this can only be found during a review of the Medical Record and need to be stated for a complete understanding of the statistical data.

The HCFA mortality data lists 82 deaths for VillaView when only 72 patients died in the hospital itself. Of the 10 who died elsewhere, 3 were discharged upon the family's request (1 was not expected to survive and it was clearly stated in the record that the family wished to care for the patient in his last days at home); the remainder of the patients were sent home in stable and improved condition. It is not known what other factors came into consideration in these deaths. Of the 72 patients in the hospital, 42% died within 3 days of admission, and of these, 21% died within hours of admission. Review of these records indicated that the patients were brought into the hospital from the Emergency Room and were not expected to survive. Their diagnoses included stroke, heart attack, and respiratory failure.

HCFA must inform the public that the measures used to predict rates do not consider how severely ill the patient is at admission or even whether the patient had a terminal illness.

-continued-

Letter to William L. Roper, M.D.
October 23, 1987
Page 3

In summary, I would like to state that although there are serious limitations to the data supplied by HCFA, VillaView does support the principle of communicating appropriate and meaningful quality of care information to consumers. We are aware that HCFA is working on a system to make this data more meaningful, and we welcome the opportunity to use this data as a means of monitoring our own quality of care measures.

Thank you for this opportunity to comment.

Sincerely,

A handwritten signature in dark ink, appearing to read "T.N. Pendleton". The signature is fluid and cursive, with the first letters of the first and last names being capitalized and prominent.

T.N. Pendleton
President

TNP:lbc

Visalia Community Hospital
1633 South Court Street, P.O. Box 911, Visalia, California 93279-0911 / 209 733-1333



October 9, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Re: HCFA Hospital Mortality Data Release

Regarding the above data release, we wish to make the following statement:

Because of the heavy concentration of cardiologists practicing at this hospital, these high risk cases result in higher death rates.

Sincerely,

A handwritten signature in dark ink, appearing to read "Neal Walther", with a long, sweeping horizontal stroke extending to the right.

Neal Walther, MD
Chairman
Medical Records/Utilization Review Committee

NW:lm1



WASHINGTON
MEDICAL
CENTER

October 14, 1987

#050401

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Sir:

We are in receipt of the mortality information concerning short term acute care hospitals, and have reviewed this data with a great deal of interest.

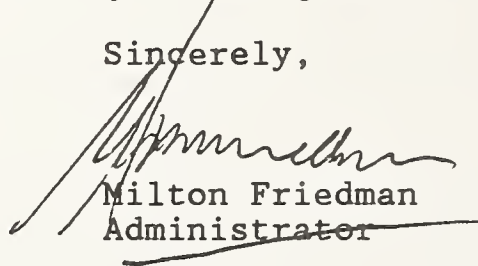
It is extremely satisfying to see this data include a wider variety of patient descriptor information, and the reclassification of this information into seventeen high risk/low risk categories rather than the DRG categories used previously to aggregate this information.

The additional use of admitting diagnosis, previous hospital admission and/or transferred, and the presence of selected co-morbidities in addition to sex, age, and principal diagnosis certainly adds a broader base to the data, and greater credibility.

In our own case, the major portion of our patient population is made up of elderly people, admitted from skilled nursing facilities with multiple severe diseases/diagnosis. It will certainly be an asset when the severity of illness factor can be included in this data as so many of the elderly are acutely ill on admission to an acute facility.

As stated in our previous responses, statistically our patients have been older than the average, more of our patients are admitted via transfers, and almost always the coexisting diseases/diagnosis add significantly to the severity of the patient on admission.

Sincerely,


Milton Friedman
Administrator

MF:mop



WATSONVILLE

COMMUNITY HOSPITAL

October 23, 1987

William Roper, M.D.
Administrator
Department of Health and Human Services
Health Care Financing Administration
The Administration
Washington, D.C. 20201

Dear Doctor Roper:

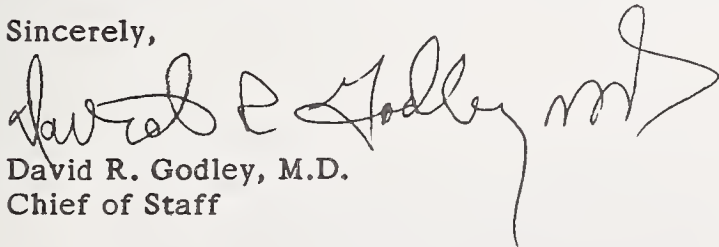
The following is in response to HCFA's release of data on hospital mortality rates. We would ask that you include the following statement when our data are released:

"Watsonville Community Hospital, our Board of Directors, Management and Medical Staff place an extremely high value on the quality of care we provide. We believe that quality can only be evaluated through a rigorous peer review program, not through statistical comparisons such as the attached mortality data. Our current Quality Assurance Plan specifies a process for comprehensive physician investigation of the care rendered to many of our patients. This includes, but is not limited to, patients who die at our hospital. When any question regarding quality arises, an investigation follows which identifies any problems, and corrective measures are taken.

The public should be aware that mortality data can be used by health care professionals to focus peer review. We at Watsonville Community Hospital have used it for that purpose and will continue to do so. No other accurate conclusions can be drawn from these data, and in fact, consumers may be misled by it. We at Watsonville Community Hospital believe that consumers do need information about their health care providers, but there are better standards to measure quality than raw mortality data. We look forward to the results of current studies which are evaluating other methods of measuring the quality of care in hospitals. These studies are being performed by organizations such as the American Hospital Association and the Joint Commission on Accreditation of Hospitals."

We appreciate the opportunity to respond to the mortality data.

Sincerely,



David R. Godley, M.D.
Chief of Staff



Paul A. Estess
Chief Executive Officer

DRG:PAE:sh

West Covina Hospital

725 South Orange Avenue
West Covina, California 91790
(818) 338-8481

October 26, 1987

William L. Roper, M. D.
Administrator
Department of Health and Human Services
Health Care Financing Administration
The Administrator
Washington, D. C. 20201

RE: Mortality Information on Medicare Patients in 1986

Dear Sir:

I read with great interest your letter of September 21, 1987 regarding mortality rates of Medicare patients at West Covina Hospital during 1986.

I believe that for accuracy, certain points must be established to explain why there appears to be a higher-than-predicted mortality rate for patients with pulmonary disease. West Covina Hospital's actual rate was reported to be 39% as opposed to a predicted range of 7%-35%.

The major reason for this difference is due to the fact that the majority of these patients were transferred to West Covina Hospital from skilled nursing facilities. Being an acute care facility, West Covina Hospital must accept these patients, many of whom were terminal, and 75% of these patients were placed on a "No Code", as per their families' requests. Consequently, our mortality rate is higher than that predicted.

I trust this information will clarify this matter.

Yours truly,

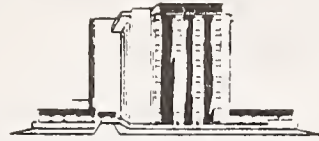


T. K. B. Fowler, Ph.D.
Administrator

KF:kt

1987 OCT 30 PM 12:09

HCFA/EXEC.SEC.



WESTERN MEDICAL CENTER

1001 NORTH TUSTIN AVENUE, SANTA ANA, CA 92705
(714) 953-3418

WAYNE D. SCHROEDER
PRESIDENT/EXECUTIVE DIRECTOR

October 26, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

ATT: William L. Roper, M.D.
Administrator

RE: Mortality Information for Medicare Provider No. 050065

Dear Dr. Roper:

The following information for Western Medical Center, Santa Ana, California, is to be included with the Hospital Specific Report for the period of calendar year 1986, prior to public disclosure:

Western Medical Center, Santa Ana, is a 327 bed acute care hospital rated as one of three facilities providing the highest level of services in Orange County. Some call it a, "hospital's hospital", because other hospitals often send difficult cases here for treatment. It is one of three hospitals and several medical facilities that make up United Western Medical Centers, the largest nonprofit, nonsectarian hospital group in Orange County.

The 1986 Hospital Specific Mortality Rate data reported by HCFA has been carefully reviewed by hospital administration, the Chief of Staff, physician Chairman of Utilization Review and Quality Assurance, and physician specialists in the diagnostic categories addressed below. We were pleased to note that our hospital's overall percentage of deaths are within the range of Predicted Mortality Rates in fifteen (15) of the sixteen (16) diagnostic categories.

The Medical Staff at Western Medical Center conducts intensive quality of care review of the medical record of every patient who expires at this facility, applying guidelines designed to objectively evaluate medical management and overall patient care. The Joint Commission on Accreditation of Hospitals recently granted an unprovisional maximum three year accreditation decision to our hospital, commenting most favorably upon our utilization review and quality assurance



UNITED WESTERN MEDICAL CENTERS. A NON-PROFIT HEALTHCARE CORPORATION DEDICATED TO COMMUNITY SERVICE.

programs in which all patients are included.

Studies were undertaken in the diagnostic categories of pulmonary disease and gastrointestinal disease. The following summarizes our findings by these categories:

PULMONARY DISEASE: The range of predicted mortality rates in this category was reported to be 14 to 30% and ours to be 31%. It should be noted that:

- The average age of this group of patients was 84 years
- The majority of patients had poor general health status with multiple underlying chronic conditions, considered high risk disorders, in addition to the disease for which they were admitted
- All but one patient were admitted from skilled nursing facilities, through the emergency room or from another acute facility, supporting the finding that the majority of patients who expired were severely ill upon admission
- The patients and/or their families requested a "No Code" (no heroic measures) for well over one-half of these patients.

GASTROINTESTINAL DISEASE: The range of predicted mortality rates in this category was reported to be 3 to 13% and ours to be 13%. It should be noted that:

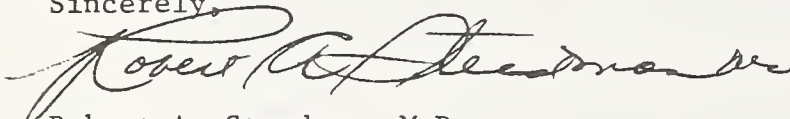
- Of the nine (9) patients who expired at the hospital, all had multiple chronic and/or high risk disorders compromising their condition
- The majority of patients were admitted from skilled nursing facilities or through the emergency room
- The patients and/or their families requested a "No Code" for over one-half of these patients.

Additional review was performed on the forty-seven (47) patients who expired outside of the hospital within thirty (30) days of their last admission. All efforts were made to identify cause of death through researching death certificates or by calling skilled nursing facilities and/or attending physicians. All medical records were then reviewed to evaluate the condition of the patient upon discharge and it was determined that all deaths were related to factors outside hospital or physician control; or, that the death was due to the natural progression of the patients' disease despite available therapy.

As a hospital, we recognize inherent limitations in assessing quality based on mortality statistics. The course of illness can be affected by a variety of circumstances, many of which had nothing to do with the patient's hospital care. This may include patient compliance with prescribed treatments, proper diagnosis, severity of illness, social factors and personal health care.

Western Medical Center will continue to strive as a leader in quality medical care by providing the best and most comprehensive care environment that can be found in this area.

Sincerely,



Robert A. Steedman, M.D.
Chief of Staff



WESTERN MEDICAL CENTER / ANAHEIM

1025 South Anaheim Boulevard, Anaheim, CA 92805
(714) 533-6220

October 23, 1987

Hospital ID # 050594

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

The following information for Western Medical Center/Anaheim is to be included with the Hospital Specific Report for the period of calendar year 1986, prior to public disclosure.

Key members of the Medical Staff and hospital Administration of Western Medical Center/Anaheim have reviewed the data recently released by HCFA and are generally pleased with the findings. A further indepth review was done in the areas of Severe Acute Heart Disease and Stroke (Cerebrovascular Accident).

Western Medical Center/Anaheim functions as a major referral center for patients with severe acute heart disease within a four county radius of the hospital. Case review in this category showed that over two-thirds of the patients arrived in full cardiac arrest or refused treatment after admission.

In the area of Strokes over one half of the patients were in poor general health due to previous strokes, heart attacks or severe heart disease. Their average age was 83 years and their families requested "No heroic measures" or "No Code" in all cases.

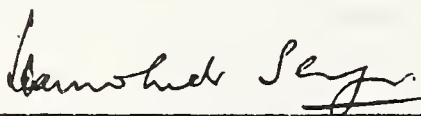
The Medical Staff and Administration of Western Medical Center/Anaheim assure that each patient is treated with dignity and the highest quality of care through an organized hospital-wide Quality Assurance Program in which all health care personnel participate.



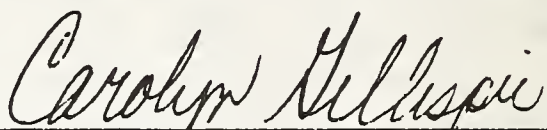
United Western Medical Centers. A non-profit healthcare corporation dedicated to community service.

William L. Roper, M.D.
Health Care Financing Administration
October 23, 1987

In summary, Western Medical Center/Anaheim is grateful for the opportunity to review and comment on this data prior to its publication. We feel this analysis has reaffirmed the high quality of care provided by our staff. As always, we will continue to strive through our Quality Assurance Program to do even better.



Harmohinder Gogia, M.D.
Chief of Staff



Carolyn Gillespie
Executive Director



Westlake Community Hospital

DATE: October 19, 1987

TO: HEALTH CARE FINANCING ADMINISTRATION
HEALTH STANDARDS & QUALITY BUREAU
HOSPITAL MORTALITY INFORMATION
P. O. BOX 26684
BALTIMORE, MARYLAND 21207

Helen Kinchen, RRA

FROM: Helen Kinchen, R.R.A
Director, Medical Records/Quality Assurance

RE: MORTALITY STATISTICS

The attached is our analysis of and comment is attached. There are variations in the numbers reported as reflected on the table attached to the comment.

If there are questions or comments on this, please contact us.

4415 S. Lakeview Canyon Rd. • Westlake Village, CA 91361 • (818) 706-8000 • (805) 497-7806

Fully accredited by the Joint Commission on Accreditation of Hospitals

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.



Westlake Community Hospital

October 19, 1987

ANALYSIS OF MORTALITY STATISTICS REPORTED BY HCFA

The statistics are confusing and misleading at best. However, if they are to be published in this form, a method should be devised to categorize according to the actual cause of death, rather than lead the readers to erroneous conclusion by using the principal diagnosis alone to categorize cause of death.

It should be emphasized that these statistics are based only on the last visit during the year of Medicare patients, not on the total number of Medicare discharges. In standard practice of compiling hospital statistics the total number of a hospital's Medicare discharges in each category would be used. Using the standard method changes the mortality rate from that reported by HCFA. Please see table attached.

It should also be emphasized that statistics based only on Medicare cases do not reflect the hospital's actual mortality rates.

4415 S. Lakeview Canyon Rd. • Westlake Village, CA 91361 • (818) 706-8000 • (805) 497-7806

Fully accredited by the Joint Commission on Accreditation of Hospitals

WESTLAKE COMMUNITY HOSPITAL

ANALYSIS OF MEDICARE DEATHS

Diagnostic Category:	Deaths Reported by HCFA		Deaths Verified by Hospital		Mortality Rat
	In-hospital	Post-hosp.	In-hospital	Post-hosp.	
All Causes	479		775		
CA -- Cancer	38	2	12	2	25.5%
CE -- Cerebrovascular accident	12	1	5	1	24.0
GC -- Gastrointestina Catastrophe*					
GI -- Gastrointestinal Disease	45	0	3	1	5.9
GU -- Urologic Disease	20	0	1	0	2.3
GY -- Gynecologic Disease	3	0	7	0	
HL -- Low Risk Heart Disease*					
HM -- Severe Chronic Heart Disease*					
HS -- Severe Acute Heart Disease	74	1	133	1	3.1
ME -- Metabolic/Electrolyte Disturbances	18	1	28	1	7.1
OP -- Orthopedic Disorders	41	0	98	0	2.0
PN -- Pulmonary Disease	41	2	86	1	8.1
RN -- Renal Disease	0	0	2	0	
SE -- Sepsis	5	0	5	0	60.0
TR -- Severe Trauma	0	0	2	0	
OP -- Ophthalmologic Disease	4	0	8	0	
UN -- Other Diagnoses	0	0	4	0	
Total -- All Categories	35	9	41	8	0.06

* Terms are not defined; i.e., gastrointestinal catastrophe vs. gastrointestinal disease, so all cases are shown as gastrointestinal disease. The same is true of Low Risk, Severe Chronic and severe Acute heart disease, so all cases are shown as Severe Acute Heart Disease.

October 26, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Gentlemen:

Thank you for giving us the opportunity to respond to the release of the hospital mortality data for the 1986 calendar year prior to its release to the public in December 1987.

Following a comprehensive review of the data we were pleased to note that the hospital's mortality statistics fell well within the expected range of mortality rates predicted by HCFA's statistical model, with the exception of one diagnostic category, "Severe Acute Heart Disease". In general, HCFA has classified Severe Acute Heart Disease in the high risk category for all diagnoses and therefore high mortality rates could be expected. Other considerations that may increase the risk of mortality for given patients include the following:

1. The admission source. Those patients admitted through the Emergency Room are generally experiencing an acute stage of their illness.
2. The patient's age. Patients over 70 years old may have less resilience to a particular illness.
3. Other complicating conditions can exacerbate the acuteness of a specific illness.

Upon a review of the medical records it was noted that of the seventeen patients whose diagnosis was Severe Acute Heart Disease and who died at Westside Hospital, the median age was 82 years old, and sixteen or 94% were admitted through the Emergency Room. In addition, many of these patients experienced other complicating conditions including chronic renal failure, cancer of the stomach with metastasis to the liver, diabetes, congestive heart failure, pulmonary edema, etc. These complicating factors increase the risk and therefore the rate of mortality.

HCFA
Health Standards and Quality Bureau
October 26, 1987
Page 2

At Westside Hospital, we have a Quality Assurance Program which includes an ongoing review by the Medical Staff of all mortality cases. This program is designed to ensure the quality and appropriateness of the services rendered to our patients, in addition to providing an opportunity to identify ways to improve patient care.

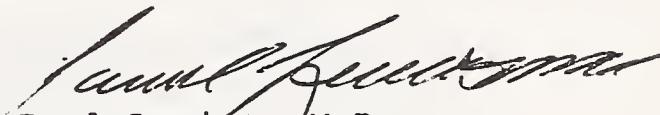
We hope that this additional information proves helpful as the public reviews the mortality statistics for Westside Hospital.

Once again, thank you for the opportunity to respond to the statistical data prior to its publication.

Sincerely,



Stuart Bramer,
Vice President/Chief Operating Officer



Paul Levitt, M.D.
Chief of Staff

cc. Michael Weinstein/President
Executive Director

Harold Karpman, M.D.
Medical Director, ICU

Carol Wilhelm, Manager
Stat Records



White Memorial Medical Center

October 23, 1987

William L. Roper M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20021

Dear Doctor Roper:

In accordance with your request we hereby respond to the data your agency will publish with regard to mortality.

We ask that you give careful consideration to the manner in which this information is released so as to be informative to the broadest possible audience. Our community includes those of Hispanic and Asian languages. We trust that you will provide information for these groups.

Should you decide to release information different from what we have seen from your office or if there are changes from the copy we have provided as a response we would appreciate the opportunity to discuss same with you.

Sincerely,


Albert R. Deininger
Executive Vice-President

XC: Harvey A. Rudisaile
President

HCFA/EXEC.SEC.
1987 OCT 26 PM 1:43

1720 Brooklyn Avenue / Los Angeles, California 90033-2481 / (213) 268-5000

WHITE MEMORIAL MEDICAL CENTER'S
RESPONSE TO
HCFA'S MORTALITY DATA REPORT

White Memorial Medical Center's records indicate the HCFA report on deaths at our institution is accurate.

At White Memorial Medical Center we classify each patient admitted to a hospital on a scale from 1 to 10. A classification of 1 indicates that the patients condition was good. A classification with a 10 would indicate a patients condition as poor. The 157 deaths occurring at White Memorial Medical Center according to the HCFA data had an average classification of 8. This means that the patients that died at White Memorial Medical Center came to the facility when they were very sick. In fact 82.6% of all deaths fell into a classification of 8, 9 or 10. The average age of a patient who died at White Memorial Medical Center was 79 years.

The HCFA information lists only the "principle" diagnosis and "principle" procedure. It does not reflect the possibility that a patient may have varying degrees of illness or in fact may be suffering from several diseases. For instance a patient may be hospitalized for pneumonia, but may also suffer from yet another disease including heart, cancer or diabetes. After a review of the deaths in the HCFA report it was clear that usually the patient had many illnesses.

White Memorial Medical Center receives patients from throughout Los Angeles County. The medical center is a 377-bed teaching hospital in the inner-city. Patients are received from nursing homes and other acute care hospitals. In fact, 31 of our 157 recorded deaths were from those who had first been admitted to another health-care institution and then transferred to White Memorial Medical Center because the patient was so ill that they required the service of a teaching medical center.

The HCFA report does not consider the quality of care given by a hospital and its medical staff. The information you see was collected without distinguishing between inner-city, suburban or rural hospitals. It also does not consider teaching hospitals as opposed to community hospitals.

Lastly, it is important to realize that most persons suffering serious illness are in a hospital when they die and not at home.



WHITTIER HOSPITAL MEDICAL CENTER

15151 Janine Drive • Whittier, California 90605 • (213) 945-3561

October 23, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, MD 21207

Re: Mortality Statistics: 1986 Medicare Patients
Medicare Provider #05175

Gentlemen:

Thank you for this opportunity to respond to the recently released 1986 Medicare Mortality Information for Whittier Hospital Medical Center. The medical staff and employees of Whittier Hospital Medical Center have always provided optimal patient care. Our review of this report confirms the effectiveness of our Quality Assurance program and medical staff review process.

In the categories of Cancer, Severe Acute Heart Disease, Pulmonary Disease, and Urologic Disease, this facility was within our acceptable statistical ranges, but chose to re-review those charts on an individual basis. Based upon our comprehensive review of this data and of the specific medical records utilized in these statistics, we at Whittier Hospital Medical Center are confident that you and any member of the public will be interested in our summary report.

1. Cancer

- a. This represents 12 deaths in a 12 month period of time.
- b. There were 3 "no codes", with family requests for no life sustaining measures due to the severity of the illness and responsiveness of the patient.
- c. The average age was 71.7 years.
- d. The Average Length of Stay was 5.5 days which indicates that these patients were in the last stages of this catastrophic disease.

2. Severe Acute Heart Disease

- a. This represents 1.3 patients within a 12 month period of time.
- b. All 16 patients had multiple serious diagnoses with an average of four additional diagnoses.
- c. All of these patients were admitted to our coronary care unit or our intensive care unit where they received specialized and intensified quality care.

William L. Roper, M.D.

Re: Mortality Statistics- Jan. 1 - Dec. 31, 1986

October 26, 1987

Page 4

UN - ALL OTHER CONDITIONS

The average age of patients in this category was 80. All patients except one had a request for "no heroic measures" or were admitted to Hospice. The remaining patient was 98 and had multiple organ failures.

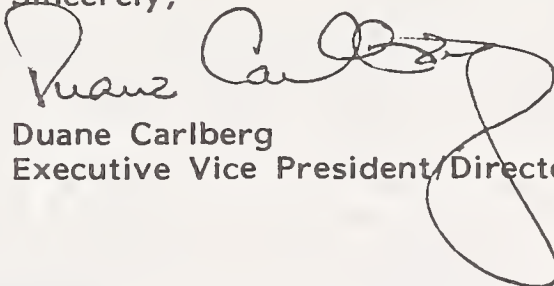
PATIENTS WHO EXPIRED OUTSIDE THE HOSPITAL BUT WITHIN 30 DAYS OF ADMISSION

It should be noted that 70% of these patients were residents of a convalescent home, were treated with resolution of acute medical problems and were transferred back to the convalescent home in stable condition. The remaining were discharged home in stable condition with visiting nursing care or with followup care at the physician's office.

The Medical Staff, as has been their practice, will continue to review all mortality cases on an individual basis. Trending analysis from these reviews is a constant endeavor to assist in identifying opportunities to improve care.

Thank you again for the opportunity to present this response.

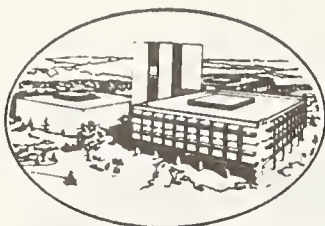
Sincerely,



Duane Carlberg
Executive Vice President/Director

DC/bp

cc: Paul Miller, M.D., Chief of Staff
Margaret Shea, California Medical Review, Inc.
Karen Logsdon, Senior Vice President
California Association of Hospitals and Health Systems



ADMINISTRATOR
Jack Hudock

Woodland Memorial Hospital

1325 Cottonwood Street • Woodland, California 95695 • (916) 662-3961

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October 26, 1987

William L. Roper, M.D.
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper,

Thank you for the opportunity to review HCFA's mortality data prior to its release to the public in December. We have reviewed the statistics and find them to be correct for our hospital.

Woodland Memorial Hospital's mortality rates fall well within or below the range of predicted mortality rates for each diagnostic category. Our medical staff performs mortality review on an on-going basis, and it is an integral part of our Quality Assurance program.

While we recognize that there are limitations to the data and the potential for misuse, we strongly support the principle of communicating appropriate and meaningful information about the quality of hospital care to consumers. We also welcome the opportunity to discuss the quality of care and services at Woodland Memorial Hospital with anyone who is interested.

Once again, thank you for the opportunity to respond to this data. If you or anyone receiving this material has additional questions, please feel free to contact me at (916) 662-3961.

Sincerely,


Jack Hudock
Administrator

JH:sw

TECHNICAL APPENDIX

METHODOLOGY

The Data Base

The basis for the present analyses is the MEDPAR file assembled and updated quarterly by the Bureau of Data Management and Strategy in HCFA. This file is constructed from information on hospitalizations submitted to HCFA by hospitals through fiscal intermediaries and from data obtained from the Social Security Administration describing certain characteristics of the patients including age, sex, race and the date of death. Because each Medicare beneficiary is assigned a unique health insurance claim number (HIC), it is possible to link hospitalizations longitudinally to ascertain prior and readmissions, and the date of death whenever and wherever it occurred.

The process of data management consisted of the following steps:

- (1) admissions to acute-care hospitals were selected, as was the array of data needed to characterize the patient and the hospitalization;
- (2) the first- and last-occurring hospitalizations, their nature as out- or in-transfers, and the number of admissions prior to the last of a given patient in a given calendar year were identified,
- (3) patients were assigned to major diagnostic categories by means of the principal diagnoses, their additional diseases identified on the basis of the secondary diagnoses, of which there were up to four for each hospitalization, and separate files were written for each diagnostic category for the first- and last-occurring hospitalization respectively. Analyses were performed on the separate files. For the purpose of assessing overall mortality rates, results obtained for the individual diagnostic categories were aggregated. As a check on the programming, a summary file of the hospital-level data was also written and analyses of this summary file were compared with the results of aggregation of the files for the diagnostic categories.

In this project, the basis used for the assessment of mortality rates was death within 30 days of admission. However, because readmissions can occur within the interval between admission and 30 days thereafter, to avoid multiple counts of deaths, the last-occurring admission in a calendar year was chosen because it is associated with the highest risk of death. The prior experience of the patient was taken into account by identifying whether the last-occurring admission represents a transfer from another acute care facility and by identifying the overall number of prior hospitalizations in the year.

The composition of the diagnostic categories and of the comorbidities was determined in part empirically and in part on the basis of clinical judgment. The diagnostic categories used in these analyses were chosen to follow medical disciplinary lines and to report principally on high-risk admissions but also on certain low-risk admissions. The empirical testing consisted of the computation of the relative risk of death associated with the category or comorbidity compared to that in a reference population by using standard statistical techniques (The Cox Proportional Hazards Model). A committee of clinical advisors was assembled to review alternatives and to assist in the design of an appropriate classification scheme. The approach adopted for the present analyses is the result of their deliberations and advice.

A list of the ICD9-CM codes included in each diagnostic category and comorbidity is found on the following pages.

Analytic Techniques

The principal analytical tool was logistic regression. Because the diagnostic categories are mutually exclusive, the analyses to ascertain the influence of patient characteristics (age group, sex, comorbidities, prior admissions and transfer status) were carried out separately for each category. If p is the probability of a given patient dying within 30 days of admission, its dependence on the patient's characteristics x_i (covariates) is specified by the logistic model as

$$\log \frac{p}{1-p} = \sum_i b_i * x_i.$$

Once the coefficients b_i have been computed, it is possible to estimate the predicted probability of dying for that patient, and, by averaging over all the patients whose treatment in a given hospital is being evaluated, the predicted mortality rate for that hospital for the individual diagnostic category as well for all categories taken together.

The second quantity required of the analyses was an estimate of the uncertainty in the mortality rate expressed as a range of predicted rates encompassing a specified proportion (95%) of the probable values. For this it is necessary to compute the variance of the probability of death at a given hospital. This quantity is conventionally taken to consist of the sampling variance and of the variance due to the uncertainty in the estimates of the regression coefficients. The latter, given the very large populations used to estimate the coefficients, is negligible compared to the former, and was confirmed to be so by direct calculation.

DIAGNOSISICD-9-CM CODES*High Risk

CA	Cancer	141-160, 162-172, 174-209
CE	Stroke	430-432, 434, 436
HS	Severe acute heart disease	410, 427.1, 427.4, 427.5, 441.0, 441.1, 441.3, 441.5, 441.9, 785.51
HM	Severe chronic heart disease	398.91, 402.01, 402.11, 402.91, 425, 428, 518.4
GC	Gastrointestinal catastrophes	551, 557, 560.0, 560.2-560.9, 570, 572-572.7, 573.4, 567, 578.0, 578.9
ME	Metabolic and electrolyte disorders	250.01-250.4, 251.0, 251.1, 255.4, 276
PN	Pulmonary disease	415.1, 416.0, 480-483, 485-516, 518-519, except 516.1, and 518.4
RN	Renal disease	580-590 except 580.81 and 590.81
SE	Sepsis	DRG: 416, 417
TR	Severe trauma	806, 808.43, 808.53, 820, 821, 828, 850.2, 850.4, 851.1-851.7, 852, 839.0-839.5, 860-867, 887, 897, 900.0, 901-904, 926, 927.0, 928.0, 929.0, 942.3, 942.4, 942.5, 946.3-946.9, 947.1-947.9, 948.2-948.9, 952, 958.0, 958.1, 958.4, 958.5

Low Risk

EY	Ophthalmologic disease	360-379
GY	Gynecologic disease	617-629
HL	Low risk heart disease	393-429, except 415.1 and 416.0 and cases in categories HS and HM
GI	Gastrointestinal disease	530-579, except 577.0, 573.1 and 573.2 and cases in category GC
GU	Urologic disease	593-609
OP	Orthopedic conditions	712-739, 810-838, 840-848 (excluding cases in category TR)

UN	All other Conditions	All other ICD 9 CM Codes
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*All of the above entries refer to ICD-9-CM codes except for the entries for Sepsis which are expressed in terms of Diagnosis Related Groups (DRGs).

COMORBIDITY

ICD-9-CM CODES

Cancer	141-160.9, 162-172.9, 174-208.9
Chronic liver disease	571-572.8
Chronic renal disease	582-583.9, 585-587
Chronic cardiovascular disease	412-414.9, 426-429.1
Chronic pulmonary disease	491-493.9, 496
Cerebrovascular degeneration/ chronic psychosis	290-290.9, 294-299.9
Hypertensive disease	402-405.99, 412-414.9
Diabetes	250.01, 250.1-250.9

(A comorbidity is taken to be present if its ICD-9-CM code appears on the bill as any one of the up to four additional diagnoses beyond the principal diagnosis.)

The sampling variance for the computation of the range of predicted mortality rates is approximately estimated by

$$[P * (1-P)]/N$$

where P is the proportion who had died of persons at risk, N, within a specified diagnostic category (or overall).

The (negligible) component of variance of the overall mortality rate, due to the regression coefficients is estimated approximately by

$$\sum_i [\sum_k \sum_{k'} P_{ijk} * (1 - P_{ijk}) * P_{ijk'} * (1 - P_{ijk'}) * x_{ijk} * C(b_i) * x_{ijk'}]$$

where the subscripts k and k' refer to individual patients, i to the diagnostic category, and j identifies the hospital. However, given the potential systematic differences among hospitals in the severity of illness of their patients, in the quality of care they receive and other unidentified factors, a further contribution to the variance, the interhospital variance, must be considered. This constant term is estimated by

$$IHV = \sum_j (P_j - \bar{P})^2 * (N_j / N_t) * (1 - 1/N_j)$$

where P_j is the predicted mortality rate, N_j the number of cases at risk at hospital j, N_t the total number of cases at risk, and $\bar{P}$ the average mortality rate, in the category under consideration. In computations using standardized residuals, the sampling variance was based on the observed mortality rate. The difficulty engendered by the occurrence of a zero mortality rate in some hospitals was overcome by a Bayesian approximation in which the mortality rate, D/N , was replaced by $(D+1)/(N+2)$, where D is the number of persons who died and N is the number at risk.

The ranges of predicted mortality rates given in this publication encompass 95% of the probable values on a logit scale to ensure that the range neither goes below zero nor above 100%. On the logit scale, the range of predicted values, P, is given by

$$R = \log \frac{P}{1-P} \pm 1.96 \frac{\sqrt{[P*(1-P)/N + IHV]}}{P*(1-P)}$$

Retransformed to the linear scale, the upper end of the range is

$$\exp(R_+) / (1 + \exp(R_+))$$

and the lower end of the range is

$$\exp(R_-) / \exp(1 + R_-)$$

where R_+ is the value of R taken with the (+) sign and R_- is the value of R taken with the (-) sign.

Two subsidiary analytical approaches were employed both as checks of the programming and the computational algorithms, and as validation tools. One was multiple linear regression in which the unit of observation was the hospital, the dependent variable the proportion of persons at risk who had died, and the independent variables within the specific diagnostic categories the proportions of the persons at risk within given characteristics used in the logistic regression. Thus, a direct comparison of the results of the logistic and the linear models was made in the case of the specific diagnostic categories. However, whereas in the computations based on logistic regression results for overall mortality were simply obtained by aggregation of the specific categories (including "Other"), in multiple linear regression analysis of this quantity, the diagnostic categories were used as covariates, along with the other patient characteristics.

The other alternative approach consisted of indirect standardization of mortality rates. The population at risk in each diagnostic category was subdivided by age-group and sex into cells within which average mortality rates were calculated. These rates were then used to compute predicted mortality rates for the age and sex-mix of each hospital.

In addition to the above, cross-validation and boot-strap analysis were used to explore the properties of the models in selected diagnostic categories. In cross-validation, the entire population at risk is randomly divided into two equal subsets and regression analyses are performed on each subset. Predicted mortality rates for the hospitals are computed both directly within each subset and by use of the patient characteristic of a given subset and the coefficients obtained in the other subset. This approach essentially tests the reproducibility of the estimation of the regression coefficients. In boot-strap analysis, replicate populations are constructed by sampling with replacement from each hospital's population. These replicate populations are of equal size but differ from each other in case-mix. Regression analyses are then performed independently on each boot-strap replicate.

Rank-order (Spearman) correlation coefficients of standardized residuals, the difference between the actual and predicted mortality rates divided by the standard error of that difference, were used to compare the results of the various analyses. In addition, the reproducibility of the identification of "outliers", hospitals whose standardized residuals were above +1.96 or below -1.96, was evaluated by ascertaining what fraction of outliers found in one year were still outliers in a subsequent year and what proportion of outliers on first-occurring admissions in 1986 were also outliers when last-occurring admission were analyzed.

SUMMARY

The tabulation of the numbers of cases at risk (i.e. the number of patients whose last discharge in 1986 was from the given hospital), of the percentage of these persons who died within 30 days of the date of admission for that hospitalization, and of the range of predicted mortality rates encompassing 95% of the probable values on the logit scale forms the core of the present publication. The observed overall mortality rates of approximately 4% of the hospitals place them more than 1.96 standard errors above the rate predicted for the case-mix of the patients of that same hospital. However, this quantity is very dependent on the precise formulation of the variance. If the interhospital variance is omitted, the number of "high outliers" rises to about 11%. In contrast, the number of "high outliers" computed by means of multiple linear regression is 2.5%. However, the variance, or more precisely, the standard error appears to behave as a scale factor affecting the shape of the distribution but to have little influence on the position of a hospital relative to the others. Thus, the Spearman correlation coefficient of residuals and of standardized residuals is about 0.95, i.e., the order is determined predominantly by the residual itself, the difference between the observed and the predicted mortality rates.

The stability of the predicted mortality rates when the case-mix of the hospital is held constant is attested to by the results of cross-validation: the Spearman correlation coefficients of standardized residuals calculated from the vector of covariates and regression coefficients estimated in the same subset with standardized residuals obtained from the same vector of covariates but regression coefficients estimated in the complementary subset are 0.99 or higher for various diagnostic categories including the most heterogeneous, cancer. In contrast, the Spearman correlation coefficients of standardized residuals obtained in successive boot-strap iterations, in which the case-mix of the hospital is allowed to vary but other characteristics are implicitly held constant, lie in the range 0.6-0.7. The implication of this last, which bears importantly on year-to-year stability of rankings, is that there remain important causes of variability in outcomes associated with variations in patient characteristics (such as severity of illness) and other factors that have not been taken into account in the models used in the present analyses.

Comparison of standardized residuals obtained by logistic regression at the patient level and by linear regression at the hospital level yields Spearman correlation coefficients that lie in the range 0.92-0.99 for the specific diagnostic categories. For the overall mortality rate, the Spearman correlation coefficient is 0.83. However, in this instance the logistic and linear model are specified differently. In the

logistic model, the results for overall mortality are obtained by simple aggregation of the results of the analyses of the specific diagnostic categories, plus the category "other", whereas in the linear model the diagnostic categories are treated as covariates. A rank-order correlation coefficient of 0.89 is also obtained when overall mortality assessed by indirect standardization is compared with the results of logistic regression. Multiple linear regression gives a convenient estimate of predictive power in the proportion of the variance accounted for by the model. For last-occurring admission and specific diagnostic categories this lies in the range of a few percent to 37%, the latter applying to the category "cancer." For overall mortality, this quantity is 59%. Almost the entire (95%) predictive power of the model for overall mortality is accounted for by ten patient characteristics: age over 85, severe acute heart disease, sepsis, pulmonary disease, cancer as a comorbidity, cerebrovascular accidents, renal disease as a comorbidity, metabolic and electrolyte disturbances, severe chronic heart disease, and age between 70 and 74.

The validity and utility of the approach used herein is best tested by comparing the results of analyses of first-and last-occurring admissions in the same calendar year and of patterns observed in successive years. When comparing first-and last-occurring admissions it is important to note that about two-thirds of hospital patients have only one discharge in a given calendar year and that one-third have multiple admissions. Therefore, some correlation will be forced by the overlap of first and last-occurring admissions. The average probability of death within 30 days of a first-occurring admissions in 1986 was 6.9% and that for the last-occurring admission was 11.7%. Clearly, these hospitalizations are associated with very different risks. For 1986 discharges, the Spearman correlation coefficient of standardized residuals for first-and last-occurring admissions was 0.83. In addition, about two-thirds of the hospitals identified as high outliers for first admissions were also high outliers based on analysis of outcomes of last-occurring admissions (71% if the interhospital variance term was not used in the calculation of the standardized residual and 64% if it was).

The Spearman correlation coefficients of standardized residuals for last-occurring admissions in 1985 and 1986 were 0.61 (0.57 if the interhospital variance component is included in the variance) and 0.51 (0.48) when 1984 and 1986 rankings are compared. The concordance of high outliers in 1985 and 1986 was 48% and for 1984 and 1986 it was 44%.







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